

**Indiana FY 2016
Preventive Health and Health Services
Block Grant**

Work Plan

Revised Work Plan for Fiscal Year 2016

Submitted by: Indiana

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Contents	Page
Executive Summary	3
Statutory and Budget Information	6
Statutory Information	6
Budget Detail	7
Summary of Allocations	8
Program, Health Objectives	10
Chronic Disease, Primary Care and Rural Health	10
HDS-1 Cardiovascular Health	11
Food Protection	16
FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments	18
Injury Prevention Program	22
IVP-4 Child Fatality Review of Child Deaths Due to External Causes	23
IVP-11 Unintentional Injury Deaths	25
Nutrition and Physical Activity	30
NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals	31
PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity	33
Office of Women's Health	36
MICH-1 Fetal and Infant Deaths	36
Public Health Performance Infrastructure	41
PHI-2 Continuing Education of Public Health Personnel	41
PHI-13 Epidemiology Services	44
PHI-15 Health Improvement Plans	48
PHI-16 Public Health Agency Quality Improvement Program	50
Sexual Assault Services (SAS) - Education and Outreach	53
IVP-40 Sexual Violence (Rape Prevention)	53
Tuberculosis (TB) Control Program/Refugee	58
IID-31 Treatment for Latent TB	59
Water Fluoridation Program	63
OH-13 Community Water Fluoridation	63

Executive Summary

- On June 6 the Advisory Committee reviewed and recommended programs for funding, contingent upon the receipt of funding for FY2016.
- On June 9, the Public Hearing was convened.
- This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2016. It is submitted by the Indiana State Department of Health (ISDH) as the designated state agency for the allocation and administration of PHHSBG funds.
- **Funding Assumptions:** The total award for the FY2016 PHHSBG is \$2,592,701. This amount is based on an allocation table distributed by CDC.
- Funding for FY2016 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: \$144,972 of this total is a mandatory allocation to the Indiana Criminal Justice Institute (ICJI) which provides this funding to reduce the prevalence of sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. Funds will be used by 17 subrecipients to provide prevention outreach and education as well as direct services.
- **Program Title:** Chronic Disease, Primary Care and Rural Health (CDPCRH)
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 - o HD5-1 Cardiovascular Health, \$535,126 of this total will be utilized to reduce the disparities and overall burden of chronic disease in Indiana. The section on Cardiovascular Health and Diabetes within CDPCRH seeks to monitor and reduce cardiovascular health (CVH) and Diabetes (DM) disparities and overall burden in Indiana; the Cancer Section within CDPC seeks to monitor and reduce cancer disparities and overall burden in Indiana; the Chronic Respiratory Disease Section in CDPC seeks to monitor and reduce disparities and overall Indiana burden related to asthma and other chronic respiratory diseases. CDPCRH also seeks to address disparities and overall burden of all chronic disease in Indiana through both organizational and public policy initiatives, health systems strategies to improve clinical care, convening statewide partners to address chronic disease, and statewide health communications.
 - The Indiana Public Health Association (IPHA) will receive \$295,470 to assist CDPCRH with the activities listed above.
 - Parkview Hospital will receive \$234,358 to assist CDPCRH with the activities listed above.
- **Program Title:** Food Protection Program
 - o FS-6 Food Preparation Practices in Food Service and Retail Establishments, \$136,320 of this total will be utilized to measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Further develop use and import of data into CodePal, the electronic system to capture and evaluate food safety inspection and investigation information. The program will also move towards a new data system vendor.
- **Program Title:** Injury Prevention Program
 - o IVP-11 Unintentional Injury Deaths, \$167,940 of this total will be utilized to continue the process begun in 2011 of developing a comprehensive injury and violence prevention program at the state health department that provides focus and direction, coordinates and finds common ground among the many prevention partners, and maximizes injury and violence prevention resources. Continue to seek

additional injury prevention grant funding and provide evidence-based primary prevention programs in Indiana, specifically related to child passenger safety and older adult falls.

- Stepping On will receive \$8,642 to assist the injury prevention program to complete these activities.
- o IVP-4 Child Fatality Review of Child Deaths Due to External Causes, \$68,469 of this total will be utilized to gain an understanding of the circumstances causing a child's death which will help prevent other deaths, poor health outcomes, and injury or disability in other children.
- Direct On Scene Education will receive \$33,426 to assist the Child Fatality Review Program with these activities.
- Local Child Fatality Review teams will receive \$33,043 to assist the Child Fatality Review Program with these activities.

• **Program Title:** Nutrition and Physical Activity

- o NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals, \$32,876, increase the number of youth and adolescents at a healthy weight by employing a spectrum of evidence based strategies in schools, school districts and out-of-school care.
- o PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity, \$32,876, will increase the number of adolescents who meet the recommended level of physical activity in a week.

• **Program Title:** Office of Women's Health

- o MICH-1 Fetal and Infant Deaths, \$13,500, the OWH will support the annual ISDH Labor of Love Infant Mortality Summit and host a State Breastfeeding Conference to ensure that high quality information related to women's health, maternal health and reducing infant death reaches the community partners that can aid the ISDH in reducing infant death in Indiana.
- Tina Mahern, Inc. will receive \$13,500 to assist the OWH program with these activities.

• **Program Title:** Office of Public Health & Performance Management (OPHPM)

- o PHI-2 Continuing Education of Public Health Personnel, \$195,116 of this total will be utilized to increase the workforce development and training opportunities for Public Health workers in Indiana utilizing the Indiana IN-TRAIN web-based training system and other eLearning tools.
- Public Health Foundation will receive \$60,000 to assist (OPHPM) with these activities.
- OPHPM will contract with a vendor that has yet to be determined for \$22,830 to help with these activities.
- o PHI-13 Epidemiology Services, \$109,184 of this total will be utilized to increase analytical capacity of epidemiologists and data analysts using SAS through a SAS expert and increasing the number of surveys of BRFSS. \$62,000 (Direct Assistance) will also be used to analyze and interpret data to assess the burden of chronic disease, provide information on the distribution and risk factors for chronic diseases necessary for public health program planning and implementation, and assist in evaluating the success of public health programs.
- Clearwater Research, Inc. will receive \$30,000 to assist the Epidemiology Resource Center with these activities.
- o PHI-15 Health Improvement Plans, \$334,995 of this total will be utilized to continue to increase the capacity for local health departments and nonprofit hospitals to conduct community health assessments and improvement plans by improving access to county level secondary data to all 92 counties in Indiana through the Indiana Indicators data dashboard website and by hiring contract staff to provide technical assistance.
- Indiana Business Research Center will receive \$18,000 to assist the OPHPM program with these activities.
- OPHPM will contract with a vendor that has yet to be determined for \$13,500 to help with these activities.

- o PHI-16 Public Health Agency Quality Improvement Program, \$214,851 of this total will be utilized to enhance the capability of Indiana health departments in the area of agency performance management and quality improvement utilizing Lean Six Sigma through a contract with Purdue Healthcare Providers and by hiring contract staff at ISDH to provide trainings.
 - Purdue Healthcare Advisors will receive \$65,000 to assist (OPHPM) with these activities.

- **Program Title:** TB/Refugee Control Program

- o IID-31 Treatment for Latent TB, \$121,412 of this total will be utilized to increase the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection and initiated treatment.

- **Program Title:** Water Fluoridation Program

- o OH-13 Community Water Fluoridation, \$204,997 of this total will be utilized monitor water fluoridation programs in communities and schools on a regular basis.
- Administrative costs: associated with the Preventive Health block Grant total \$218,067 which is less than 10% of the grant. These costs include funding for the Office of Contracts and Grants Management at ISDH.
- The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention objectives in Healthy People 2020.

Funding Priority: Under or Unfunded, State Plan (2012), Data Trend

Statutory Information

Advisory Committee Member Representation:

County and/or local health department, Medical society or organization, State health department, State or local government, Volunteer organization

Dates:

Public Hearing Date(s):

6/15/2016

Advisory Committee Date(s):

4/6/2016

6/6/2016

Current Forms signed and attached to work plan:

Certifications: Yes

Certifications and Assurances: Yes

Budget Detail for IN 2016 V1 R0	
Total Award (1+6)	\$2,592,701
A. Current Year Annual Basic	
1. Annual Basic Amount	\$2,447,729
2. Annual Basic Admin Cost	(\$218,067)
3. Direct Assistance	(\$62,000)
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$2,167,662
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	\$144,972
7. Sex Offense Admin Cost	\$0
(8.) Sub-Total Sex Offense Set Aside	\$144,972
(9.) Total Current Year Available Amount (5+8)	\$2,312,634
C. Prior Year Dollars	
10. Annual Basic	\$0
11. Sex Offense Set Aside (HO 15-35)	\$0
(12.) Total Prior Year	\$0
13. Total Available for Allocation (5+8+12)	\$2,312,634

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$2,167,662
Sex Offense Set Aside	\$144,972
Available Current Year PHHSBG Dollars	\$2,312,634
B. PHHSBG \$'s Prior Year:	
Annual Basic	\$0
Sex Offense Set Aside	\$0
Available Prior Year PHHSBG Dollars	\$0
C. Total Funds Available for Allocation	\$2,312,634

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Chronic Disease, Primary Care and Rural Health	HDS-1 Cardiovascular Health	\$535,126	\$0	\$535,126
Sub-Total		\$535,126	\$0	\$535,126
Food Protection	FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments	\$136,320	\$0	\$136,320
Sub-Total		\$136,320	\$0	\$136,320
Injury Prevention Program	IVP-4 Child Fatality Review of Child Deaths Due to External Causes	\$68,469	\$0	\$68,469
	IVP-11 Unintentional Injury Deaths	\$167,940	\$0	\$167,940
Sub-Total		\$236,409	\$0	\$236,409
Nutrition and Physical Activity	NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals	\$32,876	\$0	\$32,876
	PA-3 Adolescent Aerobic Physical Activity and Muscle- Strengthening Activity	\$32,876	\$0	\$32,876
Sub-Total		\$65,752	\$0	\$65,752
Office of Women's Health	MICH-1 Fetal and Infant Deaths	\$13,500	\$0	\$13,500
Sub-Total		\$13,500	\$0	\$13,500
Public Health Performance Infrastructure	PHI-2 Continuing Education of Public Health Personnel	\$195,116	\$0	\$195,116
	PHI-13 Epidemiology Services	\$109,184	\$0	\$109,184
	PHI-15 Health Improvement Plans	\$334,995	\$0	\$334,995
	PHI-16 Public Health Agency Quality Improvement Program	\$214,851	\$0	\$214,851
Sub-Total		\$854,146	\$0	\$854,146
Sexual Assault Services (SAS) - Education and Outreach	IVP-40 Sexual Violence (Rape Prevention)	\$144,972	\$0	\$144,972
Sub-Total		\$144,972	\$0	\$144,972

Tuberculosis (TB) Control Program/Refugee	IID-31 Treatment for Latent TB	\$121,412	\$0	\$121,412
Sub-Total		\$121,412	\$0	\$121,412
Water Fluoridation Program	OH-13 Community Water Fluoridation	\$204,997	\$0	\$204,997
Sub-Total		\$204,997	\$0	\$204,997
Grand Total		\$2,312,634	\$0	\$2,312,634

State Program Title: Chronic Disease, Primary Care and Rural Health

State Program Strategy:

Goal: Between October 2016 and September 2017, the Indiana State Department of Health (ISDH) - Division of Chronic Disease, Primary Care, and Rural Health (CDPCRH) seeks to reduce the disparities and overall burden of chronic disease in Indiana, and improve the quality of life of those individuals affected by chronic diseases. The Section on Cardiovascular Health and Diabetes within CDPCRH seeks to monitor and improve cardiovascular health (CVH) and Diabetes (DM) outcomes, and implement effective strategies for prevention; the Cancer Section within CDPCRH seeks to monitor and reduce cancer disparities and overall burden in Indiana, and improve prevention and screening behaviors; the Chronic Respiratory Disease Section seeks to monitor and reduce disparities and overall burden related to asthma and other chronic respiratory diseases. The CDPCRH also seeks to address disparities and overall burden of chronic diseases in Indiana through both organizational policies, health systems strategies to improve clinical care, convening of statewide partners to address chronic disease, and statewide health communications. Targets in burden reduction include increasing the percentage of individuals in targeted settings with their asthma, diabetes and hypertension under control to decrease morbidity and mortality associated with these conditions. Efforts to increase primary screenings for breast, cervical and colorectal cancers should reduce colorectal and cervical cancer incidence and mortality associated with these cancers. Additionally, clinical quality improvement activity will serve to reduce dependence on emergency department care for individuals with ambulatory sensitive conditions, specifically asthma, diabetes and hypertension.

Program Priorities:

- Improve surveillance, analysis, and communication of CVH, DM, Cancer, and Asthma indicators and risk factors in Indiana
- Lead coordinated statewide efforts to improve CVH, DM, Cancer, and Asthma outcomes.
- Advance evidence based public health strategies to improve the chronic disease burden in community settings through systems-level change, policy, and health communications.

Primary Strategic Partnership(s):

- **Internal:** Division of Nutrition and Physical Activity and Tobacco Prevention and Cessation
- **External:** Indiana Minority Health Coalition, Indiana Cardiovascular Health and Diabetes Coalition, Indiana Cancer Consortium, Indiana Joint Asthma Coalition, American Heart Association, Indiana Institute on Disability and Community, American Diabetes Association, American Cancer Society, American Lung Association, Indiana Public Health Association, Indiana Primary Health Care Association, and Indiana Rural Health Association.

Role of PHHSBG Funds: Strengthen state ability to provide statewide data surveillance and analysis related to chronic disease; support strategies to prevent and control high blood pressure and diabetes; convene statewide organizational partners in order to develop collaborative systems and policy initiatives to improve the state's chronic disease burden; assess initiatives related to non-provider health professionals and their role in addressing chronic disease in Indiana; support implementation and evaluation of strategies to address disease prevention and control, medication therapy management, health systems quality improvement, and complex care management; and ensure evaluation methodology utilized by chronic disease public health staff address cost effectiveness of initiatives.

Evaluation Methodology: CDPCRH follows national evaluation guidelines as put forth by the CDC Framework for Evaluation and individual CDC evaluation guides for state-based chronic disease public health programs. Annual evaluation plans are utilized to monitor processes and impact of division and section initiatives. Additionally, in order to evaluate support provided to local communities for community-wide initiatives, an evaluation plan including process and intermediate outcomes measures will be implemented in collaboration with community partners. These evaluation methods will be operationalized in the following manner:

10 1. Address health disparities and improve outcomes by preparing workforce: Evaluation will occur via process and health indicator reporting, in-person learning sessions, process mapping and key-informant interviews. Outcomes and economic data will be collected and assessed. Projects involving complex care

management, medication therapy management and non-provider community based interventions, including the use of non-traditional workforce members such as paramedics are being conducted as pilots so evaluation will focus on identifying best-practices, determining generalizability and portability of processes, and on developing an evaluation protocol for post-pilot implementation, spread and sustainability. Additionally, web-analytics will be used to assess convenience and effectiveness of internet-based resources and learning platforms.

10 2. Analytic capacity development and expansion: Evaluation will focus on measuring improvements in staff analytic skills, technical capacity and productivity. CDPCRH will work with internal partners (Maternal and Child Health, Tobacco Prevention and Cessation, Women, Infants and Children, and the Epidemiology Resource Center) to develop assessment instruments informed by Council of State and Territorial Epidemiologists and CDC competency standards. Findings will be reported to agency leadership with review by partners with the capacity to support ongoing staff development. Feedback processes will be put in place to act on the findings and further advance staff development. FTE supported through this objective will participate in agency performance evaluation processes.

10 3. Convene and mobilize state-level stakeholders to address critical health burdens related to chronic disease: Evaluation will be tailored for each stakeholder group and will address process and outcome assessment, as well as effectiveness of partnerships. The division will conduct surveys and key informant interviews with stakeholder organizations to assess reach, scope and effectiveness of activity.

Stakeholder activity will be linked to, and performance measures will be based on, HP2020 strategies and objectives. Success stories will be tracked for each organization represented. Monthly conference calls, quarterly progress reports and formal evaluation summaries will facilitate oversight of the respective groups.

State Program Setting:

Community based organization, Medical or clinical site, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO HDS-1 Cardiovascular Health

State Health Objective(s):

Between 09/2015 and 10/2016, Reduce hospitalizations and emergency room admissions and increase self-management and prevention of cardiovascular disease, diabetes, asthma, and cancer and chronic obstructive pulmonary disease (COPD) by mobilizing statewide chronic disease partners, including subject matter coalitions and a 7-county hospital system. Five coalitions will develop and update plans to address Indiana's chronic disease burden and a hospital system will design and implement a training program for paramedics and emergency services personnel to serve nursing home and home-bound individuals with chronic diseases in non-emergent settings.

Baseline:

Indiana adults have high rates of hypertension (34%), smoking (22%), obesity (32%), asthma (10%), high cholesterol (40%), and diabetes (11%). Additionally, the state demonstrates low percentages of screenings for breast (68%) cervical (73%), and colorectal cancer (63%). Surveillance indicates that 60% of hypertensives, 70% of diabetics, and 78% of asthmatics meet minimal standards of control.

Data Source:

ISDH records: Behavioral Risk Factors Surveillance System (BRFSS), hospital discharge data, mortality data, natality data, census, reporting from Indiana Primary Care Learning Collaborative

State Health Problem:

Health Burden:

Chronic diseases such as heart disease, stroke, cancer, chronic lower respiratory diseases and diabetes are the leading causes of death in Indiana. In 2014, more than 50% of all deaths were attributed to these five diseases. The financial impact of chronic diseases on Indiana's economy is substantial. In its milestone report, "An Unhealthy America: The Economic Impact of Chronic Disease," the Milken Institute (MI) illustrates the enormous economic cost of chronic diseases in the United States. Based on the 2015 America's Health Rankings by United Health Foundation and the American Public Health Association, Indiana is ranked 41 out of 50 states for overall health.

Economic Impact of Major Chronic Diseases in Indiana: (Annual estimated costs in billions)

Treatment Expenditures: **\$8.4**

Lost Productivity: **\$24.6**

Total Costs: \$32.9

Common Chronic Diseases in Indiana:

Heart Disease and Stroke

- Heart disease was the leading cause of death (13,701 deaths) in Indiana in 2014
- Stroke was the fourth leading cause of death (3,104 deaths) in Indiana in 2014
- In 2015, 32.4% of Indiana residents reported having high blood pressure
- In 2015, nearly 39.1% of those screened reported having high blood cholesterol, a risk factor for developing heart disease and stroke

Cancer

- Cancer was the second leading cause of death (13,494 deaths) in Indiana in 2014.
- More than 31,000 new cancer cases were diagnosed in Indiana in 2014, which includes 4,611 new cases of breast cancer among women and 2,977 new cases of colorectal cancer.
- Early detection for breast and colorectal cancer improves long-term outcomes, but in populations 50-75 years of age, only 8% have had a blood stool test in the past 2 years and 62% have had a sigmoidoscopy or colonoscopy within the recommended time frame. Additionally, only 72% of women 50-74 years of age have had a mammogram within two years.

Diabetes

- Diabetes was the seventh leading cause of death (1,818 deaths) in Indiana in 2014. Although diabetes is considered to be under-reported as the primary cause of death, risk of death among people with diabetes is about twice as high as people of similar age without diabetes. In the same year, over 5,000 additional deaths in Indiana listed diabetes as a contributing cause.
- In 2015, 11.4% of adults, over 574,000 individuals 18 and older, reported being diagnosed with diabetes.

Asthma

- Asthma affects an estimated 23 million people every year in the United States. In Indiana, approximately 1 in 10 (10.8%) adults (age 18 years or older) reported having asthma in 2014.
- There were 73 deaths due to asthma in 2014, an increase of 4 from 2013.
- There were 30,904 emergency room visits due to asthma in 2014 – a decrease of nearly 403 visits (1.3%) from 2013.
- Nearly 7,091 hospitalizations were recorded due to asthma in 2014, which decreased by 1.5 percent from 2013.

Target Population:

Number: 6,570,902

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 1,500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; BRFSS; hospital discharge; mortality records; natality records; Indiana Primary Care Learning Collaborative; Milken Institute. An Unhealthy America: The Economic Burden of Chronic Disease

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glynn LG, Murphy AW, Smith SM, Schroeder K, Fahey T. Interventions used to improve control of blood pressure in patients with hypertension. Cochrane Database of Systematic Reviews 2010, Issue 3.

Guide to Clinical Prevention Services (for screening); Health Affairs November 2010 issue: Designing Insurance To Improve Value in Health Care

How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's* Evidence-Based Toolbox and Guide 2008: <http://www5.cancer.org/aspx/pcmanual/default.aspx>;
<http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf>

NCI Patient Navigator Research Program <http://crchd.cancer.gov/pnp/pnpr-index.html>

Community Health Workers National Workforce Study. U. S. Department of Health and Human Services Resources and Services Administration Bureau of Health Professions. Community Health Worker National Workforce Study. 2007.
<http://bhpr.hrsa.gov/healthworkforce/chw/>

Asthma: A Business Case for Employers and Health Care

The Asheville Project <http://www.pharmacytimes.com/files/articlefiles/TheAshevilleProject.pdf>

Surgeon General's Call to Action to Promote Healthy Homes
(www.surgeongeneral.gov/topics/healthyhomes/calltoactiontopromotehealthyhomes.pdf)

Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. JAMA. 2002; 288(14):1775-9.

Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness-Part Two. JAMA 2002; 288(15):1909-14. 2002.

Flex Monitoring Team. Briefing Paper No. 34—the Evidence for Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program. Portland, ME. 2014.

Community Paramedicine Evaluation Tool. 2012. U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy: Rockville, MD.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$535,126

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Advanced workforce development (ES8)

Between 10/2015 and 09/2016, Parkview Health Network will conduct 2 trainings for paramedics and nursing home personnel in the rapid response method to identify and respond to asthma, cardiac events, chronic obstructive pulmonary disease, and sepsis.

Annual Activities:

1. Community paramedicine protocol and evaluation platform

Between 10/2015 and 09/2016, CDPCRH will work with community based emergency medical service organizations to create protocols, establish best practices, and develop evaluation processes for community paramedicine activity. Community paramedicine will capitalize on the healthcare capacity of paramedics and EMTs during non-emergent periods to maximize the reach of clinical practices and support self-management behaviors and serve as health coaches and physician extenders for targeted panels of patients to improve blood-sugar management in diabetics, improve compliance in hypertensive individuals, support pre-natal care, mitigate fall risk in seniors, and reduce re-admission for conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

Objective 2:

Chronic Disease Coalitions (ES4)

Between 10/2015 and 09/2016, The Cardiovascular and Diabetes Coalition of Indiana, Indiana Cancer Consortium, Indiana Healthy Weight Initiative, Indiana Joint Asthma Coalition, and the Task Force on Disability and Health with the oversight of CDPCRH will provide technical assistance (in the form of communication support, community-clinical linkages, data systems, economic analysis, evaluation, geospatial analysis and statistical analysis) to develop and implement strategic health improvement plans based on current disease burden and evidence-based practices to 5 groups of community-level stakeholders capable of influencing prevention, management and palliation associated with chronic diseases including asthma, cancer, cardiovascular disease and diabetes, and obesity, and populations experiencing health inequities.

Annual Activities:

1. Provide technical assistance to statewide chronic disease stakeholders to improve disease outcomes

Between 10/2015 and 09/2016, CDPCRH will convene and support community-based coalitions to provide technical assistance to 5 community-level stakeholder groups including those for cancer, asthma, obesity, cardiovascular health and diabetes, and disabilities. CDPCRH will work closely with statewide and community-based partners to ensure that strategic plans and activities are informed by scientific research, current surveillance evidence and represent best- or evidence-based practices; maximize the resources available to the coalition for purposes of coordination, communication, and effective work; and

address long-term spread and sustainability of effective chronic disease partnerships. CDPCRH will provide technical assistance to the coalition partners in the areas of evidence-based public health programming, organizational policy to address the chronic disease burden in Indiana and health systems initiatives to improve chronic disease outcomes. Additional technical assistance related to data and surveillance, evaluation and geospatial analysis will be provided to coalitions.

2. Evaluation of progress associated w/ chronic disease strategic plans in asthma, cancer & obesity

Between 10/2015 and 09/2016, CDPCRH will provide technical assistance to 5 community partnerships to support their capacity to assess statewide progress associated with their respective disease state strategic plans, including the development of a summary report on current health status for these disease areas or special populations (disabled) impacted by these diseases, a communications platform for the information resulting from the evaluation, and strategies to further progress towards achieving long-term strategic objectives. Specific topics to be addressed include asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24).

3. Strategic Planning

Between 10/2015 and 09/2016, CDPCRH will work with 5 coalitions of statewide community organizations to publish or update strategic health improvement plans associated with asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24), as well as special populations impacted by these conditions (disabilities). Included in this activity will be comprehensive surveillance, communication, and evaluation activity, with special focus on public access dashboards such as Indiana Indicators.

State Program Title: Food Protection**State Program Strategy:**

Goal: Between October 2016 and September 2017, the Indiana State Department of Health Food Protection Program (FPP) is in the process of replacing the current CodePal system, a software application that captures food inspection and investigation data electronically. The new system will be designed to improve business process, reporting capabilities, Geographic Information System (GIS) and mobile capabilities and addressing current system data sync issues. The application allows users to document any violations or deficiencies found during an inspection and activities related to investigations of foodborne illness cases. This electronic system reduces the reliance of paper for reporting of inspections and investigations. Data, such as food establishment demographics, violations, complaints, and recall and outbreak investigations, can be used on a broader state-wide level to better understand the problems and direct resources toward those issues once they become known through this data collection system. The program's goal is to continue to enlist local health departments to utilize the new system as their inspection software. For those jurisdictions that are utilizing another application, the new system is being designed to accept their food inspection data electronically through web services to import data into the new system. The web services process will allow the building of a state-wide database of food inspection data, and will be implemented with the development and use of standardized templates. FPP division in parallel will continue utilizing the CodePal system until a new system is operational around June 2017.

Program Priorities: The Senior Level Application System Analyst/Developer will work towards data conversion activities, transition of current system users to new system, bring new users on board, and to develop standardized templates for those jurisdictions that are utilizing another application to accept their food inspection data electronically through web services to import data into the new system on scheduled basis. As time permits, this position will also support users in their installation and use of this inspection software.

Primary Strategic Partnerships(s):

- **Internal:** ISDH's Food Protection Program and Office of Technology & Compliance
- **External:** Indiana local health departments and universities

Evaluation Methodology: Included in the ISDH strategic plan, strategic priorities include decreasing disease incidence and burden; improving response and preparedness networks and capabilities; better use of information and data from electronic sources to develop and sponsor outcomes-driven programs; and improving relationships and partnerships with key stakeholders, coalitions, and networks throughout the State and the nation. The development of a state-wide database of food inspection and investigation data will aid in addressing these priorities, and progress is tracked in Dashboard metrics reports. These metrics reports include specific objectives related to the functionality and growth of the system, and quarterly reports are submitted to agency leadership to monitor the progress of annual goals.

- The following Metrics reports excerpt details the 2015 key indicators by quarter.

Must Do's	2015 Strategic Initiatives	Output	Output Indicator	Owner	Goal/ Target	Report on Progress 1st Qtr 2nd Qtr 3rd Qtr 4th Qtr	Comments
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Key Strategy

1	Implementation of CodePal upgrade to allow major new enhancements and functionality for users			Krista Click	25 new Users/ Year 7/Quarter	1 st Qtr: 10 2 nd Qtr. 5 3 rd Qtr: 10 4 th Qtr: 0	10 users for Q1: LaPorte – 9; East Chicago – 1 5 users for Q2: Lawrence 1, Jasper 2, Putnam 1, Rush 1 10 users for Q3: 3 Posey, 1 Clinton, 1 East Chicago, 3 Benton, 2 Wabash
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Key Activities 2013 to achieve key strategy

1	Implementation of CodePal upgrade to allow major new enhancements and functionality for users	LDH use of CodePal	Increase number of Local Health Departments agreeing to use the CodePal software and who continue to use the system to issue permits, conduct inspections, and log complaints and ford samples.	Irene Jameson	6 LHD/ Quarter	1 st Qtr: 2 2 nd Qtr: 4 3 rd Qtr: 4 4 th Qtr: 0	2 Counties for Q1: LaPorte, Lake (East Chicago). Delays/low Numbers are due to Web Sync/Server Upgrade Project Q2: Lawrence, Jasper, Putnam, Rush
3	Implementation of CodePal upgrade to allow major new enhancements and functionality for users		Monitor percentage of local health departments reporting to the state database (CodePal)	Vacant		1 st Qtr: 24% 2 nd Qtr: 28% 3 rd Qtr: 32% 4 th Qtr: 32%	The program has moved from a stance of trying to get LHDs to use CodePal to trying to sync data to create statewide database. The software used is under evaluation.

- Work Plan – Goals/Mile Stones Activities for Year 2016 – 2017 in regards to new system activities.
 - Phase 1 - June 2016 - July 2016.
 - Kick Off Meeting and Gap Analysis
 - Phase 2 – Development, Testing and Implementation – August 2016 – July 2017.
 - August 2016 – September 2016
 - Submission of Gap Analysis Results
 - ISDH Staging Environment
 - Data Conversion

- Regulatory Codes
- October – December
 - Application Dev Configuration
 - Deploy of Dev app for State Review
 - System Test and Issue fixes
- January – June 2017
 - System Implementation in production
 - Testing
 - Training and production go live

State Program Setting:

Local health department, State health department, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments

State Health Objective(s):

Between 10/2015 and 09/2016, measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Further develop use and import of data into an electronic system to capture and evaluate food safety inspection and investigation information.

Baseline:

Currently there is not a state-wide database of food inspection and investigation data. Fast-food and full service restaurants in Indiana operate under the jurisdiction of the Indiana State Department of Health, 93 local health departments, and 3 universities. The goal is to increase the capacity by moving to a more efficient and effective system that is already incorporating national program standards into a state-wide food inspection and investigation data system.

Data Source:

Healthy People 2020, Indiana State Department of Health

State Health Problem:

Health Burden:

Consumers continue to be impacted by foodborne illness outbreaks to the tune of 48 million cases, 128,000 hospitalizations, and 3,000 deaths in this country each year (2013 FDA Model Food Code, Scallan et al). Financial burden of \$10-83 billion annually in lost productivity, pain and suffering, and medical costs is estimated (2013 FDA Model Food Code, Meade et al). The issue is that with all of our efforts, we continue to have many illnesses and loss of life. Having better and more current data in Indiana is critical so that resources can more effectively be targeted to reduce the foodborne illness risk factors that can lead to cases of disease.

The following table was included in the 2014 update to the Indiana State Health Improvement Plan (I-SHIP): Enteric illnesses are prevalent yet are underreported in Indiana, as well as across the U.S. The table below describes confirmed cases of various enteric illnesses from 2008 to 2014.

Condition	2008	2009	2010	2011	2012	2013	2014	Average
Botulism	1	0	0	1	0	0	1	0.4
Campylobacteriosis	686	646	864	750	741	875	862	774.9
Cryptosporidium	203	282	285	263	164	139	185	217.3
Giardiasis*	NR	316	399	325	227	203	168	273
Hepatitis A	20	19	11	24	11	32	20	19.6
Hepatitis E	2	2	0	3	3	4	1	2.1
Hemolytic Uremic Syndrome (HUS)	1	7	0	2	11	9	7	5.3
Listeriosis	10	10	15	11	10	11	8	10.7
Salmonellosis	641	590	786	650	782	707	733	698
Shiga-toxin producing E.coli (STEC)	104	97	144	147	191	151	168	143.1
Shigellosis	607	76	64	91	161	117	1366	354.6
Typhoid Fever	1	1	0	4	0	4	5	2.1
Vibriosis	5	3	0	2	2	9	6	3.9
Yersiniosis	9	7	13	11	10	6	13	9.9

Sources:

- I SHIP 2014-2016

<http://www.in.gov/isdh/25733.htm>

- MMWR January 8, 2016 / 64 (52);ND-923-ND-940

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6452md.htm?s_cid=mm6452md_w

- HUS rates 2013/2014 Epidemiology Resource Center ISDH

These enteric illnesses are identified by passive surveillance through identification by laboratory diagnosis or epidemiologic linkage. Indiana State Department of Health's (ISDH) current system is to follow-up with every reported case. Interviews are conducted by the local health department (LHD) in the county of residence to collect demographic, clinical, risk factor, and other pertinent information using a standardized questionnaire that is specific to the etiologic agent causing illness. These interviews are not dependent on serotype or pulsed-field gel electrophoresis (PFGE) results but are conducted upon initial notification. Information collected from LHD case interviews, reference laboratories, and the ISDH laboratory (serotype and confirmatory testing) is entered into the Indiana National Electronic Disease Surveillance System (INEDSS) for review by the Enteric Epidemiologist. Local clusters with common risk factors or serotypes are identified at this time.

In addition to passive surveillance activities, ISDH also conducts outbreak investigations for enteric illnesses. Improvements in molecular laboratory testing methods of enteric bacteria have made it easier to identify foodborne disease outbreaks at a State and National level.

The confirmed number of enteric illnesses reported above for 2013 and 2014 were provided in a recently published ISDH FPP FoodBytes newsletter (https://secure.in.gov/isdh/files/FoodbytesWinter_2016.pdf).

Target Population:

Number: 6,400,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 6,400,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Partnership for Food Protection - Business Process Evaluation and Improvement Tool for Inspection Systems (A Partnership for Food Protection Resource Document)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$136,320
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

CodePal Maintenance and Migration to New System

Between 10/2015 and 09/2016, Senior Level Application System Analyst/Developer will implement **1** new data system. Some of the important activities are data conversion, transition of current system users to new system, bring new users on board, and to develop standardized templates for those jurisdictions that are utilizing another application to accept their food inspection data electronically through web services to import data into the new system on scheduled basis. As time permits, this position will also support users in their installation and use of this inspection software.

Annual Activities:

1. Migration to New System

Between 10/2015 and 09/2016,

1. Migration to new system and with local health departments to build statewide database. Senior Level Application System Analyst/Developer will work towards migration activities from CodePal system to new system. Some of the important activities are data conversion, transition of current system users to new system, bring new users on board, and to develop standardized templates for those jurisdictions that are utilizing another application to accept their food inspection data electronically through web services to import data into the new system on scheduled basis.
2. As time permits, this position will also support users in their installation and use of this inspection software.
3. A long term electronic data collection system in Indiana will allow for more comprehensive and current data that can be effectively used by state and local food protection programs. The new system can aid in the identification of potential disease causing conditions, thereby helping the regulatory authority mitigate these situations of public health concern more expeditiously.

State Program Title: Injury Prevention Program**State Program Strategy:**

Goal: Between October 2016 and September 2017, continue developing an Injury Prevention Program for the State of Indiana that will ultimately lead to a reduction in the number of preventable injuries and deaths.

Program Priorities: The Indiana State Department of Health (ISDH) has continued to develop an organized Injury Prevention Program. The agency has maintained an injury epidemiologist to conduct injury surveillance, prepare epidemiologic reports related to injury and serve as a subject matter expert of injury incidence and risk factors. The ISDH will continue to prioritize the efforts needed to more fully develop an Injury Prevention Program for its citizens.

Primary Strategic Partners:**Internal:**

Child Fatality Review Epidemiology Resource Center
Indiana Violent Death Reporting System Program Maternal and Child Health
Office of Women's Health Trauma Program
Vital Records

External:

Attorney General's Prescription Drug Abuse Prevention Task Force Bi-weekly Health User Group GIS
CDC Injury Center
Coroners

Great Lakes and Mid-Atlantic Regional Network Indiana Criminal Justice Institute
Indiana Department of Homeland Security Midwest Injury Prevention Alliance
Indiana Hospital Association Indiana Poison Control
Indiana State Trauma Care Committee Indiana Trauma Network
Safe Kids Safe States

Senator Head's Substance Abuse and Child Safety Task Force Indiana Injury Prevention Advisory Council

State and Local Child Fatality Review Teams State Epidemiology Outcomes Workgroup

Evaluation Methodology: The development of a core Injury Prevention Program that will ultimately lead to acquisition of data, analysis, and development of appropriate activities.

The Indiana Child Fatality Review (CFR) Program will monitor the success of the projects activities by:

- The number of trainings held, as well as the number of individuals trained.
- The percentage of teams receiving technical assistance regarding mortality/morbidity data and guidance on injury prevention programs/activities.
- The percentage of teams receiving assistance funding implementation of evidence-based injury prevention programs/activities.
- The number of teams receiving Indiana-specific CFR program manuals.
- The percentage of fatality cases with improved timeliness of identification to local teams.

The ultimate measure of the success of this program will be in a decrease in the number of preventable child deaths in Indiana. However, this will be long-term trend data and might not reflect within the 12-month grant period described here.

State Program Setting:

Community based organization, Local health department, State health department, Other: Child Fatality Review Teams

FTEs (Full Time Equivalent):

Full Time Equivalent positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO IVP-4 Child Fatality Review of Child Deaths Due to External Causes

State Health Objective(s):

Between 10/2015 and 09/2016, Prevent an increase in death and hospitalization of children due to external causes through implementing best-practices needed to meet the National Center for the Review and Prevention of Child Deaths (NCRPCD) data quality standards which include reporting of timely and complete review, data entry, and quality assurance procedures so Child Fatality Review (CFR) data may be included in pediatric injury prevention and improved health outcomes.

Baseline:

In Indiana, injury is the leading cause of death for children ages 1-17 years. From 2012-2014 in Indiana, there were 681 children who died from injuries (ages 0-17 years). This is an average of 227 preventable deaths per year. The leading causes of injury and death--falls, transport-related, homicide, suicide, suffocation, and drowning--for children differ by risk factors such as age group, gender and geographic area.

Data Source:

Indiana State Department of Health, CDC, and National Center for the Review and Prevention of Child Deaths

State Health Problem:

Health Burden:

Injuries are a major public health problem across the United States and in Indiana. Injuries are not random chance events, but follow a predictable sequence of events, and can be prevented using specific strategies. In Indiana, injury is the leading cause of death for children ages 1-17 years and contribute to significant morbidity. From 2012-2014 in Indiana, there were 681 children who died from injuries (ages 0-17 years). This is an average of 227 preventable deaths every year. For every child that dies in Indiana, there are thousands of hospitalizations and hundreds of thousands Emergency Department (ED) visits. From 2011-2013, there were more than 6,000 hospitalizations and more than 430,000 ED visits. The human suffering and financial burden of pediatric injuries in Indiana is staggering.

Actionable knowledge is critical in implementing successful prevention strategies. Many child fatality teams in Indiana are newly formed, so helping to build capacity and assist in informing and implementing prevention strategies is crucial. Providing training to the teams on data quality improvement, and assisting them with using data to inform prevention strategies while helping them identify and implement evidence-based prevention programs and resources, will help catalyze and guide the teams to turn knowledge into action.

Target Population:

Number: 95,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 95,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: ISDH Vital Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$68,469

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:**Improve pediatric injury prevention programs and resources at the local level**

Between 10/2015 and 09/2016, CFR program staff will provide assistance in implementing community level, evidence-based injury prevention programs and resources to **25%** of local CFR teams.

Annual Activities:**1. Pediatric injury mortality and morbidity data**

Between 10/2015 and 09/2016, Provide statewide, regional and county specific, pediatric injury mortality and morbidity data to 100% of local teams.

2. Technical Assistance

Between 10/2015 and 09/2016, Provide technical assistance to 25% of teams to help analyze data, identify injury cause, mechanism trends and determine evidence-based injury prevention programs, activities and resources to address these issues.

3. Funding evidence-based injury prevention

Between 10/2015 and 09/2016, Provide funding to 25% of local teams and assist with the implementation of evidence-based injury prevention programs, activities and resources.

Objective 2:**Train local child fatality review teams to improve the number and quality of cases reported entered**

Between 10/2015 and 09/2016, CFR teams will increase the number of reports entered into the NCRPCD case reporting system (CRS) from 100 to **130**.

Annual Activities:**1. Regional trainings**

Between 10/2015 and 09/2016, CFR program staff will provide regional trainings to 80% of local teams in appropriate data collection and data entry into the Child Death Review (CDR) database.

2. Indiana Child Fatality Review Program Guide

Between 10/2015 and 09/2016, Based on information, suggestions and requests from local teams at the regional trainings, CFR program staff will author a program manual for Child Fatality Review (including data entry) for the state of Indiana.

3. Collaboration with DCS

Between 10/2015 and 09/2016, CFR program staff will collaborate with Department of Child Services (DCS) to improve timeliness of 80% of DCS fatality cases to be identified by local teams within 30 days of date of death.

4. Data report cards to local teams

Between 10/2015 and 09/2016, CFR program staff will analyze 100% of pediatric vital records death data to inform quality improvement of data at the local level and produce a data report to teams that outline number of cases entered into the NCRPCD CRS, updates, areas for improvement, etc.--a data report card to improve the quality of data reported to the Child Death Review database. This report card process will then continue to be used on a quarterly basis after the grant period has ended.

National Health Objective: HO IVP-11 Unintentional Injury Deaths

State Health Objective(s):

Between 10/2015 and 09/2016, the Division of Trauma and Injury Prevention will work towards reducing the number of unintentional injury deaths in Indiana by 10% through the continued development of a comprehensive injury and violence prevention program at the state health department. The program will provide prevention partners focus and direction from the state to maximize injury and violence prevention resources.

Baseline:

The age-adjusted mortality rate for Indiana in 2014 was 43.8 per 100,000. The Division of Trauma and Injury Prevention hopes to improve this rate by 10% to 39.42 per 100,000. The Healthy People 2020 goal is 36.0 per 100,000.

Data Source:

Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS)

State Health Problem:

Health Burden:

Injuries are a serious public health problem in Indiana. Injuries often result in trauma, possible lifelong disabilities, or even death. In Indiana, unintentional injury is the leading cause of death among persons 1 to 44 years of age and the fifth leading cause of death overall following heart disease, malignant neoplasms (cancer), chronic lower respiratory disease and stroke. Fatality rates and hospitalization rates are highest among persons over the age of 75. The age-adjusted mortality rate for unintentional injuries in Indiana in 2013 was 43.8 per 100,000. The two leading causes of injury death in Indiana in 2014 were unintentional poisoning and unintentional motor vehicle traffic. Unintentional injuries contribute to the greatest years of potential life lost before age 65 in Indiana, meaning younger residents are more affected by injuries than other causes and residents ages 45-54 years have the highest age-adjusted rate death rate due to unintentional injuries at 7.6 per 100,000. Within the same year, more than 18,000 Indiana residents were hospitalized due to unintentional injury and an additional 398,000 were treated in emergency departments. In addition, injury fatalities caused by intentional acts, such as homicide or suicide were among the top four causes of death in Indiana in all age groups from age 5 to 54. Unfortunately, prior to 2011, Indiana lacked the resources to support a program devoted to injury

prevention. Injury prevention is a key component of the developing statewide trauma system.

Target Population:

Number: 6,596,855

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 989,528

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$167,940

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Injury Prevention Primary Programming

Between 10/2015 and 09/2016, Injury Prevention Program Coordinator will implement 2 primary prevention programs in the state of Indiana focusing on older adult falls and child passenger safety.

Annual Activities:

1. Injury Prevention Primary Programming - Master Trainer status

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will achieve "Master Trainer" status in a variety of evidence-based prevention programs to reduce injury in Indiana's leading causes of injury by attending master trainer education events in areas focused on older adult falls and child passenger safety.

In order to become a certified child passenger safety technician instructor, one must:

- Become a certified technician and maintain your certification throughout your instructor candidacy
- Gain experience in the CPS field
- Gather the required information for the [Application for Instructor Candidacy](#)
- Participate in a Certification Course as a course assistant
- Register by paying the instructor candidate [application fee](#) after being a CPS technician for at least six months. At this time you also should contact a certified instructor to discuss who your mentor will be and which class you will participate in as part of your instructor candidacy.
- Submit the [Application for Instructor Candidacy](#) to Safe Kids at least six weeks prior to the registered course that you wish to participate in as an instructor candidate.
- Once you are approved as an instructor candidate, work with your mentor and lead instructor to prepare to teach.
- Teach a Certification Course within one year of being approved as an instructor candidate.
- The lead instructor and your mentor will determine if you have passed or failed instructor candidacy and will send Safe Kids your score along with the [Instructor Candidate Evaluation](#). Upon successful completion of instructor candidacy, your status will change to Certified Instructor.
- Continue working to improve your technical and teaching skills, fulfill your obligations as an instructor, and eventually, consider becoming a lead instructor or a mentor.

In order to become a leader in the "Stepping On" Falls Prevention Program, one must:

- Attend an annual, 3-day leader workshop.
- Coordinate peer leaders in their community (adults older than 60).
- Facilitate the seven *Stepping On* workshop sessions.
- Recruit participants.
- Arrange, reserve and set up the room and equipment for the workshop sessions.
- Prepare materials needed for the sessions.
- Invite the guest experts.
- Prepare and send out the materials needed by the guest experts.
- Create the display.

Once the injury prevention program coordinator is a Stepping On leader, they will explore the possibility of the Indiana State Department of Health becoming a Sponsoring Organization: one that supports and works with *Stepping On* Leaders and other partner organizations to ensure that workshops can take place in Indiana. The injury prevention program coordinator will also explore the requirements of becoming a Master Leader after becoming a Leader.

2. Injury Prevention Primary Programming - Technical Assistance

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will work with the injury prevention coordinators around Indiana by providing technical assistance on their various projects, activities.

3. Injury Prevention Primary Programming - Collaboration

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will participate in coalitions and work groups to help foster collaboration at the local level with the statewide goals and initiatives in injury prevention.

4. Injury Prevention Primary Programming - Continuing Education

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator and Injury Prevention Epidemiologist Consultant will attend conferences such as Safe States as a representative of Indiana. Attending these continuing education events will give the coordinator the opportunity to bring back findings to the local coalitions and work groups that can be implemented at the local level.

5. Injury Prevention Primary Programming - Social Media Outreach

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will increase social media activities via twitter and Facebook by creating actionable content that can be utilized at the local level by coalitions and work groups

6. Injury Prevention Primary Programming - Health Communications

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will create communications working to update our website, distribute and share information with partners, grantees and the CDC.

7. Injury Prevention Primary Programming - Reporting

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will help in the writing of any CDC-required report.

8. Injury Prevention Primary Programming - Grant Activities

Between 10/2015 and 09/2016, The Injury Prevention Program Coordinator will identify injury prevention grants and lead application process.

Objective 2:

Injury Prevention Resource Guide

Between 10/2015 and 09/2016, ISDH and the Injury Prevention Advisory Council (IPAC) will distribute the ISDH Injury Prevention Resource Guide to **250** injury prevention workers, specialists, health care workers, Indiana IPAC, Indiana Department of Child Services, and emergency departments in Indiana.

Annual Activities:

1. Conducting Injury Surveillance

Between 10/2015 and 09/2016, The State will conduct injury surveillance by expanding its data collection systems to include: Emergency Medical Services (EMS) (includes collecting naloxone/narcan use), hospitals, INVDRS and rehabilitation facility databases. The injury prevention epidemiologist will provide analysis for motor vehicle injuries, fall-related injury data in collaboration with other State agencies, intentional injury data collected in the Indiana Violent Death Reporting System (INVDRS) database and poisoning and overdose data.

2. Maintain Partnerships in Support of Injury Prevention

Between 10/2015 and 09/2016, Maintain partnerships with local community coalitions or organizations to promote safety, injury prevention, or violence prevention to develop injury prevention plan. The Indiana Injury Prevention Advisory Council's goal is to reduce the number and severity of preventable injuries in Indiana through leadership and advocacy. The goal is through improved collection and dissemination of data and coordination of injury prevention and control efforts, the Indiana State Department of Health will reduce injury-related morbidity and mortality in Indiana.

3. Yielding injury surveillance data

Between 10/2015 and 09/2016, The injury surveillance will yield data which we will use to drive the 5-year Injury Prevention Plan, communicate with injury prevention professionals and the general public through the development and publication of fact sheets regarding specific types of injuries, and be reported on the Trauma and Injury Prevention website of the ISDH and publish epidemiological reports related to injury such as: a tri-annual report on injuries in Indiana, an annual Fireworks Injuries report, trauma data accuracy report, etc.

4. Improving Coroner Data Collection

Between 10/2015 and 09/2016, Provide training and resources to county coroner offices to improve coroner data collection. Training may include education on the Indiana Violent Death Reporting System data system. Resources may include kits to improve samplings collected by coroners.

State Program Title: Nutrition and Physical Activity**State Program Strategy:**

Goal: Between October 2016 to September 2017, the Division of Nutrition and Physical Activity (DNPA) at the Indiana State Department of Health, seeks to reduce the disparities and overall burden of chronic disease in Indiana, and prevent incidence of overweight, obesity and the development of life-long debilitating chronic disease. As a sister division of the Division of Chronic Disease, Primary Care and Rural Health, DNPA is familiar with the burden and implications of failing to prevent the onset of leading causes of morbidity and mortality in Indiana. DNPA serves as the primary prevention of chronic disease in Indiana as it seeks to monitor and improve access to and consumption of healthy, nutritious foods, and access to and engagement in physical activity. DNPA addresses these tasks by working to change the *policies* of municipalities, organizations and communities, the *systems* in which Hoosiers interact, and the *environment* in which residents live, learn and work. DNPA works in domains across the life-span: from breastfeeding to aging in place. The group recognizes the importance of prevention in all settings. Currently, the group is active in: health promotion and marketing, built environment, access to healthy foods in the community, workplace wellness, access to physical activity in the community, and school wellness.

Program Priorities:

- Lead coordinated statewide efforts to improve the weight status of adults, children and adolescents by increasing access to and consumption of healthy foods, and increasing access to and engagement in physical activity through systems-level change, policy, and health communications.
- Improve surveillance, analysis, and communication of overweight, obesity, breastfeeding, physical activity and nutrition indicators.

Primary Strategic Partnership(s):**Internal:**

- Maternal and Child Health
- Division of Chronic Disease, Rural Health and Primary Care
- Office of Women's Health
- Office of Minority Health

External:

- Indiana Minority Health Coalition
- Indiana Cardiovascular Health and Diabetes Coalition
- American Heart Association
- Indiana Institute on Disability and Community
- American Diabetes Association
- Indiana Public Health Association
- Indiana Healthy Weight Initiative

Evaluation Methodology: DNPA follows national evaluation guidelines as put forth by the CDC Framework for Evaluation and individual CDC evaluation guides for state-based chronic disease/NPAO public health programs. Annual evaluation plans are utilized to monitor processes and impact of the division and section initiatives.

Additionally, in order to evaluate support provided to local communities for community-wide initiatives, an evaluation plan including process and intermediate outcomes measures will be implemented in collaboration with community partners.

DNPA will evaluate the progress of our goals and objectives with the weight status, fruit and vegetable consumption, and physical activity data retrieved from the Youth Risk Behavior Survey (YRBS), the policies and practices retrieved from the School Health Profiles, number of training opportunities and number of schools/students reached from those trainings, and number of presentations at statewide or regional conferences.

State Program Setting:

Child care center, Schools or school district, State health department, Other: out-of-school care

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals**State Health Objective(s):**

Between 10/2015 and 09/2016, increase the number of youth and adolescents at a healthy weight by employing a spectrum of evidence based strategies in schools, school districts and out-of-school care. DNPA contract position will partner with the Indiana Department of Education, local education agencies, Office of out of School Care, summer care and camp organizations, local YMCAs and others to improve access to healthy foods and time to be physically active for the youth and adolescents in their care.

Baseline:

The baseline of 34.5% is the percentage of schools that do not sell less nutritious foods and beverages outside of school meals. DNPA will work to increase this percentage.

Data Source:

School Health Profiles: Percentage That Did Not Sell These Less Nutritious Foods and Beverages in These Venues, Selected U.S. Sites: School Health Profiles, Principal Surveys, 2014.

State Health Problem:**Health Burden:**

According to the 2015 Youth Risk Behavior Survey, 30.9 percent of Indiana adolescents are overweight or obese, with 12.6% of adolescents reporting they don't eat fruit one or more times per day and 7.3% don't eat vegetables one or more times per day. In addition, more than 1 in 5 (21.8%) children in Indiana are food insecure. Research tells us that youth that are overweight or obese are more likely to stay overweight/obese into adulthood. This predisposition is a risk factor for serious health conditions including: cardiovascular disease, diabetes, hypertension and over a dozen types of cancers. According to the 2014 Behavioral Risk Factor Surveillance System, 66.4 percent of Indiana adults are overweight or obese. Indiana currently has the seventh highest adult obesity rate in the nation. The BRFSS 2013 shows that 43.6% of adults report that they eat fruit less than one time a day and 26.9% report that they eat vegetables less than one time a day. Additionally, only 44.0% of adults meet aerobic physical activity recommendations and only 25.6% meet muscle strengthening

Target Population:

Number: 1,550,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 335,219
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; National Center for Children in Poverty

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glickman, D. (2012). Accelerating progress in obesity prevention: Solving the weight of the nation. Washington, DC: National Academies Press.

Khan, L. K., Sobush, K., Keener, D., Goodman, K., Lowry, A., Kakietek, J., & Zaro, S. (2009). Recommended Community Strategies and Measurements to Prevent Obesity in the United States (Vol. 58, 1-26) (United States, CDC, National Center for Chronic Disease Prevention and Health Promotion). Atlanta,, GA: Centers for Disease Control and Prevention.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$32,876
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Childhood Obesity Primary Prevention Programming

Between 10/2015 and 09/2016, Childhood Obesity Program Coordinator will implement **16** school district programs across the state to improve access to healthy foods in schools and access to physical activity during the school day.

Annual Activities:

1. Childhood obesity primary prevention—technical assistance

Between 10/2015 and 09/2016, Program Coordinator will provide technical assistance and training to school districts and out-of-school time organizations across the state on best practices regarding improving access to healthy food and places to be physically active.

2. Childhood obesity primary prevention—training

Between 10/2015 and 09/2016, Program Coordinator will conduct five training opportunities (state-wide) on the topics of nutrition standards and food service training.

3. Childhood obesity primary prevention—Continuing Education

Between 10/2015 and 09/2016, Program coordinator will attend at least one national training event or

conference on the topic of childhood obesity prevention, or a specific strategy with which to prevent it.

4. Childhood obesity primary prevention—Collaboration

Between 10/2015 and 09/2016, Program coordinator will serve on three state-wide, regional, and local coalitions dedicated to childhood obesity prevention efforts. He or she will represent ISDH and promote the use of factual and evidence based strategies and efforts. Internally, program coordinator will collaborate with appropriate divisions including: Maternal and Child Health, Division of Chronic Disease, Rural Health and Primary Care, Office of Women's Health, Office of Minority Health. Additionally, program coordinator will ensure collaboration with the Indiana Department of Education, including their nutrition services department, school nurse department and physical & health education department.

5. Childhood obesity primary prevention—Statewide education

Between 10/2015 and 09/2016, Program coordinator will present at a minimum of three statewide or regional conferences regarding evidenced based practice for school, or out-of-school time professionals.

National Health Objective: HO PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity

State Health Objective(s):

Between 10/2015 and 09/2016, DNPA will increase the number of adolescents who meet the recommended level of physical activity in a week. DNPA contract position will partner with the Indiana Department of Education, local education agencies, Office of out of School Care, summer care and camp organizations, local YMCAs and others to improve access to physical activity for the youth and adolescents in their care.

Baseline:

The baseline of 46.5% is the percentage of Indiana high school students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days prior to the survey), according to the YRBA. DNPA will work to increase this percentage.

Data Source:

Youth Risk Behavior Survey (YRBS).

State Health Problem:

Health Burden:

According to the 2015 Youth Risk Behavior Survey, the percentage of Indiana high school students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey) was 46.5%.

The percentage of Indiana high school students who did not participate in at least 60 minutes of physical activity on at least 1 day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey) was 15.4%.

Target Population:

Number: 600,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 200,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: US Census Bureau; National Center for Children in Poverty; Kids Count Data Center

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glickman, D. (2012). Accelerating progress in obesity prevention: Solving the weight of the nation. Washington, DC: National Academies Press.

Khan, L. K., Sobush, K., Keener, D., Goodman, K., Lowry, A., Kakietek, J., & Zaro, S. (2009). Recommended Community Strategies and Measurements to Prevent Obesity in the United States (Vol. 58, 1-26) (United States, CDC, National Center for Chronic Disease Prevention and Health Promotion). Atlanta,, GA: Centers for Disease Control and Prevention.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$32,876

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:**Increase access to places to be physically active in Indiana**

Between 10/2015 and 09/2016, Division of Nutrition and Physical Activity (DNPA) will conduct **10** professional development trainings on increasing access to physical activity for Indiana youth and adolescents.

Annual Activities:**1. Access to physical activity—Safe Routes to School**

Between 10/2015 and 09/2016, The Coordinator will be coordinating regional trainings of school staff from a variety of school corporations and respective community members. DNPA plans to reach 15-30 people per training.

2. Access to physical activity—training

Between 10/2015 and 09/2016, The Coordinator will be training school staff from a variety of school

corporations, specifically, but not limited to, physical education teachers, regionally throughout the state. DNPA plans to reach 15-30 people per training.

3. Access to physical activity—Collaboration

Between 10/2015 and 09/2016, Program coordinator will serve on three state-wide, regional, and local coalitions dedicated to childhood obesity prevention efforts. Internally, program coordinator will collaborate with appropriate divisions including: Maternal and Child Health, Division of Chronic Disease, Rural Health and Primary Care, Office of Women's Health, Office of Minority Health. Additionally, program coordinator will ensure collaboration with the Indiana Department of Education, including their physical & health education department.

4. Access to physical activity—policy development

Between 10/2015 and 09/2016, DNPA will work with YMCAs, local school districts, out-of-school-time caregivers and other community organizations on implementing site and agency specific protocols on increasing the number of minutes of physical activity offered to youth and adolescents in their care.

State Program Title: Office of Women's Health**State Program Strategy:**

Goal: Between October 2016 and September 2017, the OWH will support the annual ISDH Labor of Love Infant Mortality Summit and host a State Breastfeeding Conference to ensure that high quality information related to women's health, maternal health and reducing infant death reaches the community partners that can aid the ISDH in reducing infant death in Indiana.

Health priority: The primary health priority for this proposal is to reduce the infant mortality rate in Indiana. The secondary health priority addressed is increasing exclusive breastfeeding, particularly for those mothers and infants at higher risk for infant mortality.

Program Priorities: The primary priorities of this program are to improve education on the risks and protective factors related to infant mortality; to help lead coordinated statewide efforts to improve health outcomes for mothers and babies at risk for infant morbidity and mortality; and to advance public health strategies to improve the rates of exclusive breastfeeding through education and health communications.

Primary Strategic Partners:**Internal:**

Maternal Child Health
Women, Infants and Children (WIC)
Division of Nutrition and Physical Activity
Office of Minority Health
Child Fatality Review
Division of Trauma and Injury Prevention
Immunization
Local Health Department Outreach

External:

Indiana Breastfeeding Coalition
Indiana Perinatal Network
Indiana Black Breastfeeding Coalition

Evaluation Methodology: The Office of Women's Health follows national evaluation guidelines as put forth by the CDC Framework for Evaluation. Evaluation methods include in-person learning sessions that will focus on process and outcome assessment of education provided. The educational sessions will convene and mobilize stakeholders to address critical health burdens related to infant mortality and evaluation will be tailored for each stakeholder group to assess reach, scope and effectiveness of the activity.

State Program Setting:

State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO MICH-1 Fetal and Infant Deaths**State Health Objective(s):**

Between 10/2015 and 09/2016, the OWH will support the annual ISDH Labor of Love Infant Mortality Summit and host a State Breastfeeding Conference to ensure that high quality information related to women's health, maternal health and reducing infant death reaches the community partners that can aid the ISDH in reducing infant death in Indiana.

Baseline:

ISDH has developed an annual Infant Mortality Summit which addresses many issues related to reducing infant death, the agency's key performance indicator. The Summit introduces multiple topics that directly relate and/or intersect with women's health and infant mortality. The Summit is approaching its fifth year, with over 700 people attending in 2015. This Conference provides important prevention and health education for community health providers.

The first annual State Breastfeeding Conference was hosted in 2015, with nearly 100 people in attendance. Breastfeeding has been shown to be positively correlated with better health outcomes for infants, including a reduction in the risk of Sudden Infant Death Syndrome (SIDS), as well as positive health outcomes for women such as reduced risk of breast and ovarian cancer, cardiovascular disease and type II diabetes.

Both conferences strive to provide high-quality speakers, evidence-based research and innovative practice techniques to diverse community partners and advocates, to ensure that they are adequately equipped to address infant mortality in their organization or roles.

Data Source:

- Birth and death certificate data
- CDC 2014 Breastfeeding Report Card
- maternity Practices in Nutrition and Care (mPINC) hospital scores
- Pregnancy Risk Assessment Monitoring System (PRAMS) (2016)
- Summit and conference registrations and
- ISDH WIC annual survey

State Health Problem:**Health Burden:**

In Indiana in 2014, the infant mortality rate was 7.1 infant deaths per 1000 births, which is well above the national average. More striking, however, is the disparity between infant mortality rates for Caucasian and African-American infants. In 2014, the infant mortality rate for white infants in Indiana was 5.9 per 1000 live births, however for black infants is was 14.7 deaths per 1000 live births. Through the promotion of health behaviors linked to lower infant mortality, including early prenatal care, safe sleep and breastfeeding, the ISDH hopes to reduce both the infant mortality rate and the health disparity.

Breastfeeding has been shown to reduce the incidence of death within the first year of life. A growing body of research over the past 15 years has shown that breastfeeding is associated with a reduction in risk for neonatal and post-neonatal death, and that this association holds in both developing and developed countries. Research has shown that it is protective against sudden infant death syndrome (SIDS), the leading causes of death for all infants 1-12 months of age, and that this effect is stronger when breastfeeding is exclusive. Individual studies have reported up to a 50 percent reduced risk of SIDS throughout infancy. A significant proportion (21 percent) of infant mortality in the US has been attributed, in part, to the increased rate of SIDS in infants who were never breastfed. It has also been confirmed that the protective effect of breastfeeding on SIDS is independent of sleep position. In addition, Respiratory syncytial virus (RSV) is the most common cause of lower respiratory tract infections among young children in the United States and worldwide. Most infants are infected before one year of age, and virtually everyone gets an RSV infection by two years of age. Each year, on average, in the United States, RSV leads to:

- 57,527 hospitalizations among children younger than five years old
- 2.1 million outpatient visits among children younger than five years old
- 25.4 deaths/10,000 admissions

Breastfeeding has been shown to lead to a decreased risk of hospitalization due to lower respiratory tract diseases, such as RSV.

From a public health perspective, breastfeeding serves both as a risk reduction and a health promotion strategy for individuals and across generations. For infants, the benefits include a decreased chance of acquiring gastrointestinal infection, ear infections, acute myelogenous leukemia, childhood asthma, atopic dermatitis, and acute lymphocytic leukemia. Four in 10 Preterm infants who are breastfed have tested higher on developmental scores at 18 months and displayed significantly higher intelligence quotients at 7 ½ - 8 years of age. Breastfed children continue to benefit from breast milk later in life with a reduced risk of being obese, developing type 2 diabetes and having high blood pressure.

Breastfeeding rates in the state of Indiana are below both the national average and Healthy People 2020 goals:

Table 1. Breastfeeding rates, all infants

Measure	HP 2020 goals	National (all infants)	Indiana (all infants)	IN vs. National
Initiation of breastfeeding	81.9	79.2	74.1	Below
Breastfeeding (6 months)	60.6	49.4	38.6	Below
Breastfeeding (12 months)	34.1	26.7	21.5	Below
Exclusive breastfeeding (3 months)	46.2	40.7	35.7	Below
Exclusive breastfeeding (6 months)	25.5	18.8	18.1	Slightly below

Resources:

- CDC Breastfeeding Report Card 2014
- Healthy People 2020 Breastfeeding Objectives
- Indiana birth and death certificates

Target Population:

Number: 6,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 1,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: CDC Breastfeeding Report Card 2014; Healthy People 2020 Breastfeeding Objectives; Indiana birth & death certificates

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: • Healthy People 2020, National Objectives on Breastfeeding

Within the Federal Government

- 1990 Innocenti Declaration, WHO and UNICEF can be found at the UNICEF Web site.
- 2000 Healthy People 2010: Objectives for Improving Health

- 2000 HHS Blueprint for Action on Breastfeeding [PDF-820KB]
 - 2010 Healthy People 2020, National Objectives on Breastfeeding
 - 2011 Surgeon General's Call to Action to Support Breastfeeding
- Major Health Professional Organizations' Policies and Positions on Breastfeeding Promotion
- American Academy of Family Physicians
 - American Academy of Pediatrics
 - American College of Nurse-Midwives [PDF-76KB]
 - American College of Obstetricians and Gynecologists
 - Optimizing Support for Breastfeeding as Part of Obstetric Practice [PDF - 116KB]
 - Academy of Nutrition and Dietetics
 - Association of Women's Health, Obstetric and Neonatal Nurses
 - National Association of Pediatric Nurse Practitioners [PDF-72KB]

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$13,500

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

Less than 10% - Minimal source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

ISDH Labor of Love Annual Infant Mortality Summit

Between 10/2015 and 09/2016, Office of Women's Health will provide evidence-based and promising strategies and research to guide prevention and intervention work to **850** community professionals, advocates and healthcare professionals.

Annual Activities:

1. Labor of Love Summit

Between 10/2015 and 09/2016, the OWH will support the annual ISDH Labor of Love Summit, which hosted over 700 community professionals, advocates and healthcare professionals in 2015. The goal for 2016/2017 is to expand programming and provide high-quality speakers that address issues related to women's health, with a strong focus on maternal and infant health.

2. Labor of Love Breastfeeding Conference

Between 10/2015 and 09/2016, the OWH will host a State Breastfeeding Conference to further support the ISDH's key indicator of reducing infant death. The goal for 2016/2017 is to increase capacity from 100 attendees to 150 in 2017.

State Program Title: Public Health Performance Infrastructure

State Program Strategy:

Goal: Between 10/2016 and 09/2017, continue to improve the overall quality and capabilities of Indiana's public health system through training events. There will be a specific focus on the quality improvement, performance management, workforce development, and other data and system infrastructure activities to support the work for public health and public health accreditation.

Program Priorities: To improve the health of Indiana, the public health infrastructure is a critical component. Improved technology for electronic reporting systems for food safety and tuberculosis (TB); a learning management system to improve the education and flow of information to public health professions; electronic display of public health data in Indiana; and the goal of improving health outcomes through quality improvement are the foundations of public health in the 21st Century.

Primary Strategic Partners: Indiana University, Purdue University, local health departments, Non-Governmental Organizations (NGO), and other state universities

Evaluation Methodology: Number of trainings, attendance at trainings, pre- and post-evaluations to compare and record knowledge gained from trainings.

State Program Setting:

Local health department, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Meganne Bunce

Position Title: Workforce Development Coordinator & eLearning

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: Patricia Truelove

Position Title: Accreditation Coordinator

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: Sarah Seward

Position Title: Director, Office of Public Health Performance Mgt

State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 3

Total FTEs Funded: 3.00

National Health Objective: HO PHI-2 Continuing Education of Public Health Personnel

State Health Objective(s):

Between 10/2015 and 09/2016, Increase the workforce development and training opportunities for Public Health workers in Indiana.

Baseline:

The U.S. Department of Health and Human Services 2010 report on *Priority Areas for Improvement of Quality in Public Health* cited Workforce Development as a priority area to improve public health. Numerous challenges continue to face the public health workforce, including job cuts, non-competitive wages, and lack of education opportunities. Increasing opportunities through distance education, partnerships, and required trainings focusing on public health, health care regulation, and public health accreditation related activities. The desire is to increase utilization of the IN-TRAIN system through the Public Health Foundation to a minimum of 10 program areas by the end of the funding period to develop

e-learning opportunities for healthcare professionals throughout the state. This is a primary source of engagement in professional development for public health workers. The Office of Public Health Performance Management now has the infrastructure in place to fully support IN-TRAIN and develop courses and publish them to the web platform. There are currently 8 registered users in the state of Indiana. The goal would be to increase this number by 5% by the end of the funding period.

Data Source:

- US Department of Health and Human Services
- Indiana Census Data
- Indiana Local Health Department (LHD) employee count

State Health Problem:

Health Burden:

The public health workforce in Indiana currently lacks many of the core competencies necessary to fully and positively impact the health of the populations they serve. While the majority are competent in their own individual duties, most are not competent in the 10 essential public health services and how their duties fit in to the overall provision of these services. This is not an issue that is unique to Indiana. The National Academy for Sciences' 2002 report on *The Future of the Public's Health in the 21st Century* cited figures released jointly by the CDC and the Agency for Toxic Substances and Disease Registry in 2001 which indicated that "80% of the current public health workforce lacks formal training in public health." According to the Association of Schools of Public Health, many physicians, nurses and other health professionals graduate with little to no ground in the concept of prevention or population health (2011). In 2012, Indiana opened two recognized schools of public health. Although this is a major accomplishment, the improvement in training won't be recognized for several years. As public health departments continue to lose jobs and an aging workforce, the question for Indiana is will public health departments replace those jobs with more educated and properly trained individuals as they will cost the health departments more money.

This lack of basic public health competencies is widespread. It is seen in both small, rural local health departments and in large, urban local health departments. The problem continues to worsen in many areas because new employees are often only trained in their day-to-day functions and are not provided with the complete picture of public health. Subsequently, most public health agencies in Indiana do not operate at full efficiency. Therefore, the target population is the workforce of local health departments in Indiana as well as the Indiana State Department of Health. The workforce will include the workforce in public health as well as local boards of health.

The workplan includes offering continuing education opportunities to local health departments through health officer meetings, monthly webcasts, and public health nurses meetings and conferences. Additional opportunities will be developed through the ISDH partnership with the Public Health Foundation and the purchase of TrainingFinder Real-time Affiliate Integrated Network (TRAIN) (subscription maintenance is made possible through Block Grant). The Workforce Development Coordinator, who is funded through PHHS Block Grant will be launching this system and developing future learning opportunities with both internal and external partners for public health in Indiana. ISDH will also be funding a position for an E-Learning Developer to assist in the creation of online learning modules for Public Health Professionals within the state of Indiana.

Resources:

US Department of Health and Human Services
Indiana Census Data
Indiana Local Health Department employee count

Target Population:

Number: 93

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Disparate Population:

Number: 65

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board Standards and Measures

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$195,116

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:**Provide access to educational resources and trainings.**

Between 10/2015 and 09/2016, ISDH and contractors will conduct 5 trainings/education opportunities for public health workforce.

Annual Activities:**1. Analyze training data**

Between 10/2015 and 09/2016, Continue to collect data from training participants to determine success of the training and assess gaps in training that will be addressed in future educational events.

2. E-Learning modules

Between 10/2015 and 09/2016, Develop E-Learning position to work with internal ISDH to create online learning modules to be hosted on ISDH Learning Management System (LMS), Indiana TrainingFinder Real-time Affiliate Integrated Network (IN-TRAIN).

3. Local Health Departments and IN-TRAIN

Between 10/2015 and 09/2016, Identify new training opportunities for LHDs through the IN-TRAIN learning management system and collect evaluation and assessment data.

4. Workforce Development and Public Health Accreditation

Between 10/2015 and 09/2016, Domain 8 is focused on workforce development and is a requirement for Public Health Accreditation. ISDH is one of the primary resources for LHDs to receive continuing education and workforce development activities. Workforce development activities will include access to all public health workers to the IN-TRAIN e-learning system. This work is supported by the addition of the e-Learning Developer in Office of Public Health Performance Management Infrastructure. This activity is also supported by strong internship opportunities throughout the agency to be enhanced by adding work shadowing and project experience for public health students at all levels (Masters, PhD, Faculty). Development of ISDH employees is also vital to the continued growth of the agency. ISDH plans to deepen its engagement with the Fairbanks School of Public Health and establish a certification process for ISDH employees to complete course work to attain a Certification in Public Health (CPH). These courses will be readily available and accessible to employees as they will be hosted at the ISDH.

5. Leadership at All Levels Training

Between 10/2015 and 09/2016, Host the intermediate and advanced series of Leadership at All Levels for ISDH and other state agency staff to develop and encourage leadership skills within the agency. The impact of these trainings will result in a more knowledgeable, informed workforce in Indiana.

6. Educational Resources and Training that Address the ISDH Priority Areas.

Between 10/2015 and 09/2016, The Office of Public Health and Performance Management (OPHPM) will provide educational resources, training and events that focus on the agency's top priorities: infant mortality, adult obesity and adult smoking.

7. Support Continuing Education Events.

Between 10/2015 and 09/2016, Cover conference registration fees for ISDH employees. Provide continuing education opportunities on and off site for ISDH and Local Health Department (LHD) staff.

National Health Objective: HO PHI-13 Epidemiology Services

State Health Objective(s):

Between 10/2015 and 09/2016, Increase analytical capacity of epidemiologists and data analysts using Statistical Analysis Software (SAS).

CDR Claudine Samanic will assist the Indiana State Department of Health to use health data, especially population-based data, to perform the essential functions of chronic disease epidemiology through direct assistance assignment by the Centers for Disease Control and Prevention.

Baseline:

Our agency's epidemiologists and data analysts have a general knowledge of SAS, but have requested assistance for managing datasets pertaining to their specific program area (e.g., removing duplicates, date formatting issues); how to produce a variety of output (e.g., tables, graphs); and how to program the SAS logic for complicated data extractions. These staff had also requested assistance with SAS Proc Tabulate and Operational Data Store (ODS), and two seminars have been provided on these topics. Matt Kaag, contract SAS Senior Data Analyst, now provides SAS tips a few times a month via list serve that discuss the answers to SAS questions from the epidemiologists and data analysts.

Our agency's epidemiologists work well in the areas of chronic disease, injury, environmental health, minority health, and other non-infectious disease programs. However, directors of these programs have identified areas of assistance and mentorship for these epidemiologists, particularly with data analysis and interpretation, improvement of surveillance systems, identifying health disparities, preparation and distribution of reports, and program-evaluation. In addition, some public health programs do not have specific epidemiologic capacity, including substance abuse, women's health, occupational health, and others, and would greatly benefit from having epidemiologic support.

Data Source:

Records kept by Matt Kaag, contract Senior Data Analyst/SAS Programmer

State Health Problem:

Health Burden:

In order to monitor health outcomes, timely and accurate data are required. It currently takes more than 14 months to produce final natality and mortality datasets, which delays the analysis of interventions in place to improve the health of residents. Continuing to reduce the time needed to produce final natality and mortality datasets will permit epidemiologists and data analysts faster access to factors affecting

health outcomes, including infant mortality, and deaths from drug overdose and chronic diseases. For example, new innovative programs are being put in place to decrease infant mortality, especially for African Americans (Indiana had the second highest black infant mortality rate in 2013). Access to timely data is needed to monitor changes in such risk factors as smoking during pregnancy, access to care, prenatal visits and low birth weight in addition to the number of infant deaths. The sooner this information is available to analysts, the faster it can be determined what interventions reduce infant deaths in our state.

Chronic diseases, including heart disease, cancer, cerebrovascular incidents, and complications from diabetes and obesity are leading causes of morbidity and mortality in Indiana. In order to monitor health outcomes, timely and accurate data are required. Access to timely data is needed to monitor changes in risk factors for these diseases and prepare reports that drive policy and intervention. Substance abuse, particularly injection of opioids, has fueled increases in hepatitis C statewide and the emergence of an outbreak of human immunodeficiency virus (HIV) in 2015. Having epidemiologic capacity for these conditions is critical to creation, implementation, and evaluation of programs to address these conditions and decrease subsequent morbidity and mortality.

Target Population:

Number: 6,570,901

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants, Safety Organizations

Disparate Population:

Number: 2,500,000

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants, Safety Organizations

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Follow guidelines established by the National Center for Health Statistics in the production of mortality and natality datasets, reports and analysis. Adherence to CDC protocols for BRFSS data collection, analysis and reporting.

CDR Samanic will assist the ISDH to use health data, especially population-based data, to perform essential functions of chronic disease epidemiology as described in the CSTE 2004 paper: Essential functions of Chronic Disease Epidemiology in State Health Departments.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$109,184

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Essential Functions of Chronic Disease Epidemiology in State Health Departments.

Between 10/2015 and 09/2016, Claudine Samanic will provide technical support to 2 peer review panels to evaluate national grant applications regarding CDC funding related to chronic disease.

Annual Activities:

1. General Consultation and Assistance to ISDH.

Between 10/2015 and 09/2016, Provide general consultation and assistance to the ISDH Chronic Disease Division, Environmental Health Division, and Trauma and Injury Prevention Division, among others, within the Indiana State Department of Health.

2. Collaboration and linkage at ISDH.

Between 10/2015 and 09/2016, Ensure collaboration and linkage between the ISDH Chronic Disease Division in the use of data collection tools and development of various reports.

3. Surveillance and Evaluation Activities

Between 10/2015 and 09/2016, Ensure collaboration with surveillance and evaluation activities among ISDH Chronic Disease Division in data collection and reports.

4. Establishing a Peer Review System

Between 10/2015 and 09/2016, Establish and maintain a peer review system for reviewing reports and documents distributed to various national audiences.

5. Manuscript Development

Between 10/2015 and 09/2016, Develop manuscripts to be published in peer-reviewed scientific publications.

6. Conference Presentations

Between 10/2015 and 09/2016, Deliver a presentation at the annual conference of the Council of State and Territorial Epidemiologists (CSTE) or one other professional meeting.

7. Meet professional requirements of the United States Public Health Service.

Between 10/2015 and 09/2016,

- When requested and deemed a national emergency, deploy for a period of no longer than two weeks.
- Participate in advisory committees and workgroups (example: Hispanic Officers Advisory Committee, Health Services Professional Advisory Committee, Epidemiology workgroup) to provide advice and consultation to the Surgeon General's office (OSG) on issues related to the corps.
- Participate in leadership and work development conference calls during working hours.
- Develop and contribute to the drafting of standard operating procedures and other PHS documents during working hours.
- Represent the PHS at professional meetings.
- Wear PHS uniform daily.

8. Participation in Workgroups

Between 10/2015 and 09/2016, Participate in CSTE workgroups.

Objective 2:

Increase Analytic Capacity of Epidemiologists and Data Analysts

Between 10/2015 and 09/2016, Matt Kaag, contract Senior Data Analyst, will conduct 2 SAS trainings to agency epidemiologists and data analysts in addition to individual assistance.

Annual Activities:

1. Instruct SAS short courses

Between 10/2015 and 09/2016, Matt Kaag will provide 2 trainings for agency epidemiologists and data analysts on data management, analysis, and presentation using the SAS software platform.

2. Provide technical consultation

Between 10/2015 and 09/2016, Matt Kaag will provide individual consultation/assistance as needed to

epidemiologists and data analysts on SAS programming and analyses.

Objective 3:

Increase number of surveys completed in the 2017 Indiana BRFSS survey

Between 10/2015 and 09/2016, Linda Stemnock and contractor will conduct 560 surveys for the 2017 Indiana BRFSS.

Annual Activities:

1. Increase number of BRFSS surveys completed to increase data availability and demographic detail

Between 10/2015 and 09/2016, An estimated 560 landline and cell phone interviews will be added to the Indiana 2017 BRFSS survey via contract with Clearwater Research, Inc. (BRFSS contractor for Indiana). The percent of cell phone interviews will be determined in the fall of 2016 (30% is the baseline established by CDC, and this will most likely increase). These additional surveys will aid in the tracking of risk factors and preventive actions, identify health disparities, and support strategic health improvement plans (HP2020 PHI-7, 8, 14, 15). The Advisory Committee voted to approve funding to be allocated for BRFSS data collection.

Objective 4:

Support production of the annual reports and datasets

Between 10/2015 and 09/2016, Matt Kaag, contract Senior Data Analyst will develop 1 core files and create templates used to generate annual reports.

Annual Activities:

1. Download birth and death files from the Genesis application

Between 10/2015 and 09/2016, Matt Kaag will download at least monthly Genesis, State and Territorial Exchange of Vital Events (STEVE), and resident out of state (ROOS) data and process the files in preparation for the ISDH Data Analysis Team's (DAT) use.

This activity will be accomplished by providing descriptions of tables added to our annual mortality and natality reports, published tables using hospital discharge data by county, monthly datasets provided to specific program areas, and BRFSS newsletters topics. Examples: (1) the DAT provided additional data in the 2014 Indiana natality report, published in December 2015. New tables were added: percent of mothers breastfeeding upon hospital discharge by county; and for births to Hispanic mothers, additional tables include the number and percent of live births by method of delivery and age of mother, general fertility rates and total fertility rates by county of residence, and the number and crude birth rate by county of residence. (2) Up-to-date files of out-of-state Indiana births and deaths are now sent on a monthly basis to MCH to monitor infant deaths. (3) The BRFSS Coordinator will also continue to collaborate with chronic disease staff to produce BRFSS newsletters that provide additional information on these conditions, especially those affecting populations at risk.

2. Produce datasets for ISDH epidemiologists

Between 10/2015 and 09/2016, Matt Kaag will generate a provisional birth and death dataset within 6 months and final dataset within 12 months of year end. Datasets will be posed for internal use by agency epidemiologists and data analysts.

National Health Objective: HO PHI-15 Health Improvement Plans

State Health Objective(s):

Between 10/2015 and 09/2016, Continue to increase the capacity for local health departments and nonprofit hospitals to conduct community health assessments and improvement plans by improving access to county level secondary data to all 92 counties in Indiana through the Indiana Indicators data dashboard website.

Baseline:

ISDH and the Indiana Hospital Association have developed a central location for hospitals, local health departments to access county level data in one central location (www.indianaindicators.org). This website will house public health data, SES data and other resources for those doing health improvement plans, including information on best practices.

Data Source:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Hospital Discharge Data
- County Health Rankings
- Vital records
- Census data
- Community economic data

State Health Problem:

Health Burden:

Many communities do not know the overall health burden of their community based on solid data. They also don't know what best practices are to address those health issues. This dashboard will provide national, state and local data to make the best improvement plan possible.

The 1,000,000 disparate populations include counties that do not have nonprofit hospitals or are very rural, small, and underfunded organizations. (US Census)

Resources:

BRFSS, Hospital Discharge Data, County Health Rankings, vital records, census data, community economic data

Target Population:

Number: 6,000,000

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants

Disparate Population:

Number: 1,000,000

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Standards and Measures

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$334,995

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Data Warehouse Maintenance

Between 10/2015 and 09/2016, ISDH, Indiana Hospital Association, Indiana Business Research Center will update 1 data dashboard website. Utilize a contract staff member with the Epidemiology Resource Center for data resources and GIS capabilities.

Annual Activities:

1. Community Health Assessments

Between 10/2015 and 09/2016, Community Health Assessments are required by both nonprofit hospitals to demonstrate community benefit for the IRS requirements under the Patient and Protection Affordable Care Act. Local health departments are required to do a local health assessment for public health accreditation. In addition, both the state department of health and the local health departments are required to have a data profiles report for public health accreditation (Domain 1). Local health departments will utilize the Indiana Indicators website to provide the data needed to do their local health assessment for public health accreditation. This website will assist all interested parties in accomplishing their goals while also reducing staff time at ISDH for individual data requests. To provide a high quality product with the most up to date data resources, the ISDH will collaborate with the Indiana Business Research Center (IBRC) to host www.indianaindicators.org website. This website will provide a vast array of information for local health departments to effectively complete community health assessments, which are a part of PHAB standards and measures (Domain 1). ISDH plans to expand utilization of the Indiana Indicators resource by collecting feedback from hospitals through the Indiana Hospital Association to identify their data needs to assist in community health assessments, as well. The analysis of these activities will create a workplan to develop those areas of the website that will better serve all entities that utilize www.indianaindicators.org as their data repository for community health assessments including those in and outside of public health.

2. Partner meetings

Between 10/2015 and 09/2016, Conduct quarterly meeting with partners and partner with appropriate agencies to ensure policies and procedures.

3. Indiana Indicators data plan

Between 10/2015 and 09/2016, Develop a data plan for appropriate data to be included on the website including enhancements on the website that will allow for downloadable PDF data spreadsheets, maps, and other tools to increase transparency of data between counties. Website enhancements include: updating the website with new tools and data layout, update data and evaluate the website.

National Health Objective: HO PHI-16 Public Health Agency Quality Improvement Program

State Health Objective(s):

Between 10/2015 and 09/2016, Enhance the capability of Indiana health departments in the area of agency performance management and quality improvement utilizing Lean Six Sigma (LSS).

Baseline:

ISDH has worked toward an agency-wide performance management system that also includes Lean Six Sigma quality improvement methodology. The goal is to expand training within ISDH and provide Lean Practitioner for basic LSS skills as well as Rapid Improvement Event facilitation for process improvement initiatives within the agency.

Data Source:

- ISDH documentation
- Purdue Healthcare Advisors Lean Six Sigma for Public Health
- Public Health Accreditation Board
- Public Health Foundation
- Indiana State Budget Agency
- Indiana Census Data

State Health Problem:

Health Burden:

Local health department funding has been reduced each and every year. ISDH provides \$7,000,000 across the 93 local health departments but this will be reduced by 3% next funding cycle. Health departments' budgets were reduced due to legislation changes on property taxes and the downward turn of the economy. With the implementation of Affordable Care Act (ACA), local health departments will need to start moving toward efficiency and performance driven results. As both state and federal dollars are requiring more outcome driven data sources, quality improvement training and performance management training will help Local Health Departments (LHDs) become quality driven organizations.

Resources:

ISDH documentation
Purdue Healthcare Advisors Lean Six Sigma for Public Health
Public Health Accreditation Board
Public Health Foundation
Indiana State Budget Agency
Indiana Census Data

Target Population:

Number: 93
Infrastructure Groups: State and Local Health Departments

Disparate Population:

Number: 93
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board
Public Health Foundation
Indiana Census

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$214,851
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Lean Training

Between 10/2015 and 09/2016, ISDH, Purdue Healthcare Advisors will implement **1-2** Lean Practitioner training courses and 8-10 Rapid Improvement Events.

Annual Activities:**1. ISDH Lean Practitioner Training**

Between 10/2015 and 09/2016, Train 10-20 state health department staff in Lean Practitioner Training. The Lean Practitioner training series is a multi-session program that provides the opportunity for staff to obtain knowledge and skills around Lean Six Sigma methodology as well as to serve as Lean leaders in the organization.

2. ISDH Lean Daily Improvement Training

Between 10/2015 and 09/2016, Implement trainings at ISDH for Lean Daily Improvement techniques, reaching a total of 15-20 staff members. Quality Improvement is a key foundation for public health accreditation and is required for each domain and is the key component for Domain 9. To achieve accreditation ISDH must demonstrate quality improvement implementation and trained staff.

Objective 2:**Quality Improvement Dashboard**

Between 10/2015 and 09/2016, ISDH will develop **1** quality improvement dashboard through the utilization of Oracle Business Solutions to generate an agency electronic dashboard system. This dashboard will serve to be reflective of the agency's performance metrics and create transparency through data reporting throughout the agency's executive team and the Governor's office.

Annual Activities:**1. Quality Improvement Dashboard**

Between 10/2015 and 09/2016, The Office of Public Health Performance Management will work with the Office of Technology and Compliance to develop a Quality Improvement Dashboard. This is an integral part of developing a performance management system. These activities are supportive of the agency strategic plan, the agency dashboards, and quality improvement. The impact of this system and associated trainings will result in a more knowledgeable, informed workforce in Indiana.

2. Workforce Development Training

Between 10/2015 and 09/2016, Provide workforce development plan trainings to local health departments interested in public health accreditation. Developing a workforce development plan is supportive of developing an agency performance management system. The impact of these trainings will result in a more knowledgeable, informed workforce in Indiana.

State Program Title: Sexual Assault Services (SAS) - Education and Outreach

State Program Strategy:

Goal: Between 10/2016 and 09/2017, continue to reduce the prevalence of rape and sexual violence in the State of Indiana.

Program Priorities: Local victim service providers awarded SAS funds will provide sexual violence prevention outreach and education to targeted audiences in their local communities and also provide direct services to victims of sexual violence.

Primary Strategic Partnerships(s):

External: ISDH and 17 service providers in all areas of the state.

Evaluation Methodology: Evaluation methodology includes presentation evaluations and data on numbers reached through outreach and education and through direct victim services. These numbers include: number of youth and adults reached through prevention education initiatives funded through this grant broken out by age group; number of contacts with victims of sexual violence broken out by gender and age; and how victims were served (number of victims provided services through crisis intervention, crisis hotlines, support groups and other services).

State Program Setting:

Community based organization, Faith based organization, Rape crisis center, Schools or school district, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2015 and 09/2016, The purpose of the SAS program remains to reduce the prevalence of sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. Funds will be used by 17 sub-recipients to provide prevention outreach and education as well as direct services.

Baseline:

In order to most accurately reflect the number of rape/sexual assaults in the state, our researchers look at two numbers: 1) the available UCR data (raw data; not formulized by the FBI to fill in missing data) and 2) the number of forensic medical exam claims submitted by hospitals for payment by the state Victims Compensation area.

- Reported rapes/sexual assaults

Year	Available UCR- (raw data not formulized)	Sexual Assault Claims submitted for payment
2009	1,604	2,357
2010	1,634	1,761
2011	1,601	2,357
2012	1,441	2,349
2013	1,224	2,437
2014	Not Available	2,597
2015	Not Available	2,106

• Non-reports

Since non-reports cannot be tracked it is difficult to provide these numbers. Estimates on the number presenting to a hospital emergency room for a forensic medical exam and/or reporting to the police are between 25 to 47%. Using a 31% - 47% reporting rate, it can be *estimated* that 3,664 to 5,730 rapes could occur annually in Indiana.

Data Source:

Notartis Institutes of Biomedical Research (NIBRs), Indiana Criminal Justice Institute (ICJI) Victims Compensation Claims

State Health Problem:

Health Burden:

Practitioners and researchers estimate only three in ten victims actually report a sexual assault. Anecdotal evidence comes in from across the state of victims seeking counseling months and sometimes years following an unreported assault. However, for planning and funding purposes some sort of hard data is required. In that regard, the fact that Indiana is one of only two states without mandatory UCR data reporting somewhat handicaps our ability to provide quantitative hard data as other states can provide. Our data analysis center reports that approximately 40% of our 92 counties report and those cover more than 85% of the population of Indiana.

On December 14, 2011, the Center for Disease Control released the National Intimate Partner and Sexual Violence Survey which listed Indiana as having the **8th highest rate of interpersonal violence in the country**. IPV combines rape, physical violence and stalking. Indiana continues to deal with the serious problem of sexual violence. Anecdotally we hear from hospital staff and Sexual Assault Nurse Examiners (SANEs) that the number of child sexual assault cases is "exploding", to quote one SANE in the Indianapolis area.

In order to more clearly understand the social and environmental issues impacting this data, the Indiana Criminal Justice Institute contracted with Indiana University to research this issue. In August 2015, ICJI was presented with the final research report "*An Investigation into Adolescent Sexual Assault Underreporting in the State of Indiana*" by John Parrish-Sprowl, Ph.D – Director of the Global Health Communication Center at Indiana University. ICJI used state funds to follow up on the CDC report as well as a 2014 release prepared by Saint Mary's College, Notre Dame. This study found the number of Indiana high school girls who reported forced sexual activity was approximately **seven percent** higher than the national rate. Additionally, the CDC National Intimate Partner and Sexual Violence Survey provided an in-depth look into the struggles Indiana faces with Interpersonal Violence (IPV combines rape, physical violence and stalking).

As startling as the reports are, practitioners and researchers estimate only three in ten victims actually report sexual assault. Anecdotal evidence comes in from across the state of victims seeking counseling, months - and sometimes years - following an unreported assault. However, for planning and funding purposes, there is a need for hard data. Unfortunately, Indiana is one of only two states without mandatory UCR data reporting. The lack of mandatory reporting handicaps our ability to provide quantitative hard data that other states are able to provide. Our data analysis center reports that approximately 40 percent of our 92 counties, covering approximately 85 percent of the population of Indiana, report UCR data.

Economic Costs: In 2008, National Institute of Justice researchers estimated that each **rape costs** approximately. \$151,423 (Delisi Hidden **costs** in health care). The costs to the state of this public health problem include the following:

- potential costs of hospital/ER visits for exam
- rape kit
- testing and prophylactic medications
- cold storage of rape kits and evidence for one year
- transportation of evidence

- advocacy services
- therapeutic counseling
- loss of income if the victim misses work or loses her job

There continue to be higher than average rates of sexual violence in Indiana and the need for prevention, intervention, and treatment programs is ever pressing. The continuation of funding will allow for continued prevention outreach and education as well as the provision of direct services. The anticipated outcome is that the number of sexual violence incidents can be further reduced particularly among the youth of the state.

Target Population:

Number: 1,583,245

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 1,583,245

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Other: •Intervention to Reduce Distress in Adult Victims of Sexual Violence or Rape: a Systematic View (2013 Regehr, Alaggia, Dennis).

•Trauma Informed Care and Structured and unstructured Interaction Programs (Chard, 1995).

•Sanctuary Model of Trauma Informed Care.

•Trauma Informed Care Protocols and Best Practices (www.NSVRC.org/Trauma).

•Mayo Clinic Healthy Lifestyles: Stress Management Validated Support Group Model •Trauma Informed Art Therapy ® (PTSD approach).

•Trauma Focused Cognizant Behavioral Therapy.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$144,972

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$144,972

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Extend coordinated, audience-appropriate sexual violence prevention outreach and education program

Between 10/2015 and 09/2016, Subrecipient prevention outreach education presenters will provide presentations to **8000** students and adults in Indiana.

Annual Activities:

1. Provide sexual violence prevention outreach and education.

Between 10/2015 and 09/2016,

- Provide current and generally accepted sexual violence prevention programs within local area, ensuring coordination with current RPE (Rape Prevention) program providers when appropriate. Examples include Teen Dating and Healthy Relationships, Love is Respect, Campus Sexual Assault and Relationship Violence Prevention program, and others which incorporate behavior and social change theories into the programs.
 - Provide workshops and training that meet the needs of the community including training for athletic teams, EMS first responders, law enforcement, prosecutors, etc.
 - Provide prevention and intervention information on an informal basis to individuals; during a counseling session, on a crisis line call, etc.

PERFORMANCE MEASURES

Below are examples of performance measures that will be included in SAS reports at the end of each quarter:

1. Number of youth and adults reached through prevention education initiatives funded through this grant broken out by age group.
2. Number of contacts with victims of sexual violence broken out by gender and age.
 - (a) How victims were served (number of victims provided services through crisis intervention, crisis hotlines, support groups and other services):
 - Number of hotline crisis calls.
 - Individual counseling hours broken out by age and gender.
 - Group session counseling hours broken out by age and gender.

Objective 2:

Improve and enhance service and response initiatives to victims of sexual violence.

Between 10/2015 and 09/2016, Sub awards will be administered by state staff in the Indiana Criminal Justice Institute's Victim Services Division. Direct victim services will be provided by qualified staff of ICJI's sixteen SAS funded Subrecipients. Some are rape crisis centers and others are dual Domestic Violence/Sexual Assault centers. They will provide services to **200** victims of sexual violence.

Annual Activities:

1. Provide direct service to victims of sexual violence.

Between 10/2015 and 09/2016, Trained educators or counselors will provide a variety of trauma-informed care from emergency response to a hospital to meet with a victim, to explaining the rape examination process to further medical and legal education as needed. Services may be provided to any victim of sexual violence at any point in the life span continuum.

State Program Title: Tuberculosis (TB) Control Program/Refugee

State Program Strategy:

Goal: Between 10/2016 and 09/2017, the main goal of the TB Control, Prevention and Elimination Program is to decrease the morbidity and mortality caused by tuberculosis in Indiana, prevent transmission of tuberculosis to others, provide TB education to all TB stakeholders, and ensure the completion of therapy for persons who start treatment for TB disease and TB infection. Additionally, there is an increased focus of targeted testing of the high risk groups in Indiana; thereby increasing the percentage of newly diagnosed TB infection cases that start and complete treatment.

Program Priorities:

1. Early diagnosis of TB disease and infection
2. Completion of appropriate therapy for all cases of TB disease and infection
3. Prompt identification and evaluation of high and medium risk contacts through effective contact investigation activities
4. Screening and treatment of TB infection in persons in targeted high-risk populations

Primary Strategic Partnerships(s):

- **Internal:** Indiana State Department of Health Laboratories
- **External:** Local Health Departments

Evaluation Methodology: The ISDH TB program follows national evaluation TB guidelines set by the CDC. Additionally, the program conducts internal quality assurance measures. In an effort to decrease TB morbidity and mortality, the program evaluation component will focus on evaluating treatment initiation and completion for both TB infection and TB disease persons. The program's TB database TB Statewide Investigating, Monitoring and Surveillance System (SWIMSS), its medication management module, and contact investigation modules will be utilized to obtain data for the evaluation. Queries will be run to identify how many patients were entered appropriately and completely evaluated, how many started and completed treatment within the recommended guidelines. Analysis will be conducted on the specific variables identified such as: number of patients, high risk groups, treatment start date, and treatment completed, etc. Additionally the TB epidemiologist will review all data submitted individually, and any issues identified will be discussed with the submitting LHD and the regional nurse consultant

In Indiana, the local health departments with the technical support of the Indiana State Department of Health (ISDH) are responsible for case management of TB patients. Local health departments provide basic tuberculosis services which include tuberculosis screening, patient assessment and referral for medical care, delivery of anti-tuberculosis medications, case management, contact investigations, and directly observed therapy. The state is responsible for surveillance, policy development, public education and strategic leadership. This partnership is critical in the control and elimination of TB in Indiana. On 12/25/2015, latent tuberculosis infection (LTBI) became a reportable condition in Indiana. This is in line with national trends and the Center for Disease Control and Prevention's focus on successfully treating LTBI to prevent progression to TB disease. This new law means additional reporting for the LHDs. Having a user-friendly computerized case management system that includes medication management modules that collects all required information and also provides space for additional notes on each patient will make data gathering timelier, more complete and more accurate.

Success of progress goals will include:

- 1) The completion of enhancements to the current computer application to make it more user-friendly.
- 2) Provide space for notes and all inclusion of all needed variables in the contact investigation module
- 3) Increased data accuracy

The overall success of the project will be evaluated by an increase in the number of persons that complete

adequate treatment for TB infection.

State Program Setting:

Child care center, Community health center, Home, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

National Health Objective: HO IID-31 Treatment for Latent TB

State Health Objective(s):

Between 10/2015 and 09/2016, Increase the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection and initiated treatment to 74% for cohort year 2014, 79% for cohort year 2015, and 81% for cohort year 2016.

Baseline:

The baseline set for Healthy People 2020 is 81% (from 2015). Indiana's baseline for 2014 which is the most recent year for which data is available is 82%.

Data Source:

Aggregate Reports for Tuberculosis Program Evaluation; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC/NCHHSTP).

National TB Surveillance System (NTBSS)

Indiana Tuberculosis Control Program--2015 Annual Report

State Health Problem:

Health Burden:

TB cannot be eliminated in the United States and in Indiana without increased efforts to test and treat LTBI, especially among the high risk groups. Up to 13 million persons in the US have LTBI. Per CDC, The majority of cases of TB disease that occur in foreign born persons result from reactivation of LTBI rather than newly acquired infection. (Approximately 80% of the TB cases in the United States are reactivation TB which means the individuals went through a period of latent TB infection before progressing to TB disease). In Indiana, more than half of the TB cases in 2015 (57.8%) were among foreign-born persons, which mirrors the disparity seen at the national level. Racial/ethnic minorities continue to be disproportionately affected by TB within the United States including Indiana. Asians continue to be the racial/ethnic group with the largest number of TB cases. In Indiana, the majority of foreign born persons with TB originated from the following five nations: Burma, Mexico, India, China, and Vietnam The higher proportion of TB cases occurring in foreign-born persons compared with U.S.-born persons illustrates the close relationship between the global TB burden and disease patterns in the United States. The established pattern of increasing proportions of TB cases occurring in the foreign-born population reaffirms the need to support and strengthen TB control efforts with both internal and external partners.

Eliminating TB therefore requires a new approach that will focus on the diagnosis and treatment of LTBI, especially in the high risk populations, and effective management of contacts to active TB patients. There is strong need for TB education and outreach to healthcare providers, TB

stakeholders and community partners especially those servicing the high risk populations. Many of those at high risk for LTBI, who need to be reached and identified do not seek care traditionally at the local health departments, but are seen by private community providers and health care centers. ISDH and local health departments need to build partnerships with all these key TB stakeholders who often have access to this valuable information. All of this new information on LTBI must now be reported accurately and timely to the ISDH TB Program via SWIMSS.

With the new communicable disease reporting rule (410 1AC 1-2.5-76), local health departments will now report a lot more data, more often into TB SWIMSS. It is therefore imperative that these enhancements be completed.

Target Population:

Number: 6,596,855

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 936,754

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: United States Census Bureau--

<http://quickfacts.census.gov/qfd/states/18000.html>

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$121,412

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Enhancement of computer application for contact investigations

Between 10/2015 and 09/2016, Contract program developer--Swamy Buddha; TB epidemiologist--Kelly White; chief nurse--Midia Fulano; regional nurses--Tiffiney Helms and Jill Brock will develop **2** areas in the current application which are logical flow of variables and information, and clearly defined variables such as outcomes of contact investigation. Completion of the two new areas which are addition of notes field option for each contact entered and a search function so that the database can be searched to see if a new TB patient has ever been a contact to an active case of TB before. Provision of a webinar to local health department nurses on how to use the enhanced contact investigation module.

Annual Activities:

1. Review logical flow of variables and business rules in the contact investigation module

Between 10/2015 and 09/2016, The TB/Refugee Epidemiologist, chief nurse and focus group from local health departments will review the contact investigation module, test the new modules, and make recommendations if needed.

2. Build the enhanced functionality of logical flow of information, etc.

Between 10/2015 and 09/2016, The IT programmer will develop a more logical flow of information, outcome variables and business rules recommended by the staff on the development server and then test it's functionality on the test server and finally move the new functionality to the production server.

3. Build the new functionality of a note field, search option, & the related business rules

Between 10/2015 and 09/2016, The IT programmer will complete the development of the note fields for each contact where additional information about the contact can be recorded and saved. Example: phone numbers, directions, times available, relation to the TB case, where they had contact with the case, etc.

The search option and related business rules will make it possible for the regional nurses and the epidemiologist to search for and identify if a current patient or contact has been named in prior contact investigations. This will help identify potential places of transmission resulting in better identification of contacts that may have TB infection and need to be treated.

4. Provide training on use of new functionality in the contact investigation module

Between 10/2015 and 09/2016, Via a webinar to be broadcast to all county health departments, the epidemiologist and the IT programmer will provide training on the new module so that local health department nurses will be able to easily use the newly enhanced module and comply with timely and accurate reporting of contact outcomes including completion of treatment.

Objective 2:

Enhancement of the computer application system TB forms - Latent TB form (LTBI)

Between 10/2015 and 09/2016, Contract program developer--Swamy Buddha; TB epidemiologist- Kelly White; chief nurse consultant- Midia Fulano. will develop **2** new fields based on the new reporting requirements. The completion of the two new fields include new medication regimens and dosages; requesting medications through ISDH and disabling some drop down variables to make the program run more efficiently. Provision of a webinar to local health department nurses on how to use the enhanced LTBI forms will be made available. The new updated form will be sent to all local health departments.

Annual Activities:

1. Develop and add the enhanced functionality to LTBI forms.

Between 10/2015 and 09/2016, The IT programmer will develop and add to LTBI forms the variables and business rules recommended by the staff on the development server and then test it's functionality on the test server and move the new functionality to production server.

State Program Title: Water Fluoridation Program

State Program Strategy:

Goal: Between 10/2016 and 09/2017, the goal of the Water Fluoridation Program is to promote water fluoridation and monitor water fluoridation systems across the state to assure that the majority of the population of the state of Indiana continue to receive the benefits of water fluoridation

Program Priorities:

> Inspect water fluoridation systems in communities and schools across the state to ensure they maintain optimum fluoride levels.

> Educate mayors, town councils, water system boards and citizens as to the benefits, cost effectiveness and safety of water fluoridation to prevent the elimination of water fluoridation in communities.

Primary Strategic Partnerships(s):

- **Internal:** ISDH Oral Health

- **External:** Indiana Dental Association, Indiana Dept. of Environmental Management Drinking Water Division, Centers for Disease Control and Prevention

Evaluation Methodology: The field staff is expected to make at least 220 inspections of water fluoridation systems per year and to respond to any high fluoride levels (2.0ppm or above) within five business days. Field staff is expected to train any new water fluoridation system operators within 10 business days of being notified of the new operator and to retrain existing operators as needed. Field staff is also required to attend at least two professional water treatment operators meetings in order to keep up with water treatment technology and network with water fluoridation operators. The staff is also required to input up to date data into the Water Fluoridation Reporting System (WFRS). The program will evaluate progress through regular reports to the program director.

State Program Setting:

Schools or school district, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: James Powers

Position Title: General Sanitarian Supervisor 4/6NF4

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: Fred Finney

Position Title: Water Fluoridation Consultant III/1LK3

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: Eric Newlon

Position Title: Water Fluoridation Consultant III/1LK3

State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 3

Total FTEs Funded: 3.00

National Health Objective: HO OH-13 Community Water Fluoridation

State Health Objective(s):

Between 10/2015 and 09/2016, monitor water fluoridation programs in communities and schools on a regular basis.

Baseline:

In Indiana there are 249 fluoridated community water systems, 20 fluoridated rural school water systems and 118 consecutive water systems that purchase water from a fluoridated system. The objective of this program is to monitor all fluoridated water systems through surveillance visits and lab test results, and prevent the reduction in the number of fluoride systems that operate at optimum levels and maintain the 95% of the state's population that are served by a water system that has an optimal level of fluoride.

Data Source:

Results from the tests run on weekly samples submitted to the state laboratory.

State Health Problem:

Health Burden:

Over the last five years there have been 14 towns, cities, or water districts that have eliminate their water fluoridation programs due to budget issues or anti-fluoridation activities. Another six communities have considered eliminating their fluoride programs but decided to continue after hearing presentations from representatives of this program with support from local dentists, local health departments and the Indiana Dental Association. Studies have shown that when a community discontinues water fluoridation, the decay rates return to pre-fluoridation levels. Maintaining water fluoridation programs in communities prevents an increase in dental decay levels, which contributes to the overall health of those who live in those communities.

Target Population:

Number: 4,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 4,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The fluoridation program follows the CDC guidelines for fluoride system operation by working with fluoride system operators to maintain fluoride at the optimal levels and perfecting testing procedures. Recent changes in the recommended level of fluoride in drinking water implemented by HHS have led the CDC to prepare operational tolerance guidance that will be implemented by the Indiana Fluoridation Program.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: \$204,997

Total Prior Year Funds Allocated to Health Objective: \$0

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Maintain Water Systems with Optimal Fluoride Levels

Between 10/2015 and 09/2016, James Powers will maintain 95% - the percentage of people in Indiana on public water supplies that have access to fluoridated water.

Annual Activities:

1. Monitor Fluoride Samples

Between 10/2015 and 09/2016, Staff will monitor fluoride samples from all water supplies for optimal levels. Staff will respond when out of range by reviewing, on a weekly basis, the test results from all the fluoride samples sent in to the state lab for that period. When a community's test results indicate that the fluoride level is out of range, the fluoridation field staff schedule a visit or contact the community water plant operator to resolve the issue as soon as possible.

2. Consultations with town/city official or waste district board members

Between 10/2015 and 09/2016, When city/town officials or a water district board is considering the discontinuation of fluoridation, staff will meet with them to discuss the public health benefits of continuing. Staff will also recruit local dentists in the area to help.